

**Behind the doors: an ethnographic account of
operating room nursing practice**

submitted by

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requirements for the degree of Master of Nursing.**

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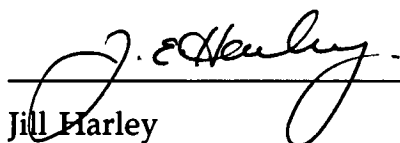
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Statement of authorship

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May 1997

Abstract

The practice of the operating room nurse is hidden from most nurses and patients behind the doors of the theatre suite. This 'hidden' world, shrouds operating room nursing practice in an air of mystery. Nurses outside the operating room may only guess at how the day to day reality of nursing practice in the operating room is constructed. The role of the operating room nurse is described within the literature as having a 'perioperative' focus which encompasses operating room nursing care throughout the patient's experience of surgery.

The question driving this thesis asks operating room nurses how they describe their practice and explores the day to day practice of these nurses through the stories they tell. Using an ethnographic methodology, six operating room nurses share their stories which depict their understandings of the nurse's role in the operating room and communicate their experiences of practice.

Within the data chapters the nurses tell stories of coming to theatre and their understandings of the role of the operating room nurse. With the exception of one nurse, the understandings of the nurses in the focus group contrast sharply with the notions of the 'perioperative' role contained within the professional literature.

The second of the data chapters focuses on the stories the nurses tell of their experiences in operating room nursing practice. The stories communicate the biomedical influence on nursing practice in the operating room as the nurses' views of the 'object body' are revealed. The nurse's role is also exposed to be a series of tasks which are directed to the support of the surgical team.

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CHAPTER ONE: SETTING THE SCENE

Within the operating room (OR), nursing practice occurs behind a set of closed doors, away from the eyes of the public, other nurses and health professionals. The doors to the OR open only if you are able to appease certain gate keepers. By this statement I mean that access to the OR is available to a so called privileged few whose reason for being there may be legitimated by those who carefully monitor the events occurring within the theatre suite. The closed doors and restricted access to the OR act to hide from others the 'reality' of nursing practice in this space. Thus, I would suggest that the perceptions of nursing practice in the OR held by nurses outside of this space may be somewhat limited.

Steelman, Bulechek and McCloskey (1994:786) assert that, 'a great deal of confusion exists among ... other health care providers ... about the contributions made by perioperative nurses to surgical patients' outcomes'. Both the literature and my own experiences suggest that the role as it is practised by the OR nurse is under threat. The OR nursing role has also been subjected to many nurses' and health professionals' assertions that it is a technical role and, therefore, may be one suited to technicians rather than nurses. Competing perceptions of what constructs OR nursing practice held by nurses outside of the OR may serve to create one of the myths, of which many abound and often lie unexamined in our nursing culture. My experiences as an OR nurse suggest to me that a 'false' impression of both the nurse's role in the OR and the perceived closeness of the relationship between the nurses and the medical staff appears to exist and serves to create one of these myths.

My own interest in exploring nursing practice in the operating room has led me to ask how other nurses experience their roles in the OR. Throughout the text you will notice that I have purposely highlighted certain words or phrases by placing them within quotation marks. This emphasis suggests that I hold the meaning or application of these words in question and thus raises particular issues in relation to the context in which they are used.

The staff of the OR, most of whom are nurses, surround the patient and govern the conduct of the patient's surgical experience. Nurses work together with surgeons and anaesthetists and form a close knit 'team' in providing the patient with appropriate perioperative care. Nurses practising outside the OR tend to see OR nurses as being strongly aligned with the surgeons. Indeed, this perception is not discouraged by OR nurses and it certainly was the image of OR nursing practice I was presented with as a student nurse and again as a newly registered nurse. I believe that nurses outside OR nursing tend to hold this view and that it has helped to perpetuate this myth I suggested earlier which relates to nurses' roles and the relations with medical staff within the OR.

When I had completed my general nurse training at a large city hospital I had decided that there could be no worse a fate than being 'just a nurse'. Being 'just a nurse' to me meant working in the general wards. I had spent much of my third year as a student in the specialty areas of intensive care, emergency medicine and the operating room and I believed that the nurses within these areas had greater worth attached to their practice. I too wanted to assume this worth within my own practice. My seduction by the world of science and technology was complete and I was looking for a place in which I could be more than 'just a nurse'.

With my self esteem buoyant, I began the heady journey of being a 'good' theatre nurse. To me this meant I had the ability to impress the surgeons and anaesthetists with my competent technical and procedural skills and my organisational ability. The 'good' theatre nurse is *always* in control and in possession of a pleasant demeanour — yet another myth which is part of the OR nursing culture.

I slowly developed the 'good' theatre nurse attributes and I enjoyed my role in the theatre 'team', but my self esteem and feelings of being a valued member of the team did not last long. Although, initially the appreciation of my technical skills by the surgeons made me feel as though I was part of the 'team', I realised that I was not valued for my knowledge beyond that which underpinned my technical skills. I found that my attempts to speak out concerning a procedure or a patient's treatment were largely ignored and that my speech in the medically dominated space of the operating theatres was regarded as insignificant. I watched other OR nurses in practice and wondered if they experienced a discomfort similar to my own.

It appeared that nurses shared opinions between themselves, but they did not appear to openly converse with the surgeons. The speech the nurses engaged in with the surgeons tended to be that of instruction, by the surgeon, his provision of information and, at times, condemnation of nurses' [in]action. This type of speech could hardly be called a dialogue, when words generally flow unilaterally, from surgeon to nurse. It appeared that sharing in decision-making and discussions around the patient rarely took place between nurses and doctors. This is not to say that when nurses are in a space of their own they fail to speak. bell hooks (1986:124) remembers from her own childhood as a black girl child in a southern American community that, '... dialogue, the sharing of speech and recognition, took place not between the

mother and child, or mother and male authority figure but with other black women'.

The male authority figures to which hooks (1986) refers exist in all aspects of society and culture. Within the OR the surgeon is the male authority figure and it is he who decides who has the right to speak and with whom. The space within each individual operating theatre is also controlled by physicians who possess 'legitimate' knowledge. This 'legitimate' knowledge is scientific knowledge which, within our Western society, is both highly regarded and rarely questioned. After learning lessons within the OR associated with the right to speak and that which constituted legitimate worthwhile knowledge, my colleagues and I assumed a form of overt silence and spoke only where it was permissible. As a (female) nurse I had learned (and now felt) that I had no legitimate right to speak. As hooks (1986:124) observes, this silence on my part was 'the sign of woman's submission to patriarchal authority'. Instead we colonised the space in the tearoom and it was here that we shared our dialogue as nurses.

As I struggled to continue within my nursing practice world I looked for something which would perhaps assist me to understand my experiences in the OR and help to explain why things were the way they were. Having embarked on this search, I enrolled in a Master of Nursing degree and discovered through the curriculum that science was but one way of knowing and understanding the world. Among many others, feminist and critical theories were offered as ways of critiquing and understanding our world and the ways we are positioned/constituted within it as nurses and as women. As I continued to read, discuss, debate and 'reason' with critical and feminist theories I discovered how others had dealt with concerns similar to mine. I was excited but extremely confronted. My beliefs and values were being turned upside down and I found that the understandings I

had of the ways of the world and my own experiences were open to other interpretations which revealed issues of gender and power. A quote from one of Lather's students explains the difficulty in reflecting on the way we are in the world in order to empower ourselves and the feelings of resistance one might feel. For this woman, resistance was;

... a word for the fear, dislike, hesitance most people have about turning their lives upside down and watch everything they have ever learned disintegrate into lies. "Empowerment" may be liberating, but it is also a lot of hard work and new responsibility to sort through one's life and rebuild according to one's own values and choices (Lather 1991:76).

I identified closely with what this woman (a student, like myself) was saying but, in addition, I felt that engaging with this form of learning was a release for me. As a woman I had experienced certain difficulties in relating and understanding my experiences within a patriarchal framework. My journey through the feminist and critical literature continued and I began to examine nursing practice in the operating theatres through my journal. I reflected upon the stories I had heard about OR nursing practice and those I had to tell — what I had seen and what I had experienced. I had always believed that the nurse-patient relationship was central to the nursing role but I was beginning to see that the technical role was more central and the former more peripheral. Examination of the professional literature about the OR shows that much of the rhetoric around nurse-patient relationships is developed through arguments for 'preoperative visiting' and the adoption of roles such as 'patient advocate' (see Marshall, 1994; Brougham & Berry, 1994; Kneedler & Dodge, 1991; Pereira, 1986).

Sowing the Seeds of a Question

Within the context of the Masters degree I decided that I would explore how OR nurses described their practice and embarked on a small ethnography with five OR nurses in a focus group. I felt that ethnography would enable me to explore nursing practice whilst exposing the cultural terrain in which it is located. In choosing this method I was influenced by the recent work of Street (1992a) and Walker (1993) who have provided important insights into the work of clinical nurses and nursing culture in areas other than the OR. I attempted to place a critical framework to my interpretation of the stories in order to raise some of the political, social and historical issues embedded in the OR culture.

An exploration of the OR literature pertaining to the description of OR nursing practice or the OR nurses' role revealed that limited research had been undertaken. The majority of the literature dealing with the OR nursing role was confined to papers which fell into broad categories of role definition, role expansion to perioperative nursing and instructional literature seeking to inform nurses in the OR of what should be contained within their roles.

This study builds on the existing literature in an attempt to gain a more critical understanding of OR nursing practice and culture from theorising aspects of operating room nursing culture through the stories and experiences of five OR nurses. The stories told present an insight into the ways in which OR nurses practise and speak of their day to day experiences in practice.

CHAPTER TWO: THE NURSE'S ROLE IN THE OR — WHAT IT SHOULD BE AND WHAT IT IS

Nurses undertaking scholarly endeavours have begun to realise the innate value of formally describing and exploring what it is they do as nurses (Anastasio & Foldy, 1995). Authors such as Walker (1993), Street (1992a) and Lawler (1991) have provided an in depth look at general nursing practice and nursing culture, but little work of a descriptive nature has been done to examine nursing practice within specialty areas. Hence in this research, I set out to describe how a small group of nurses described their world of practice through an ethnographic study.

Prior to embarking on the study I sought to develop a background understanding of the OR nursing role as it is presented in the scholarly journals. A search of the OR nursing literature within the last ten years was undertaken with a review of major journals and texts. I have placed the literature into two categories; firstly, papers in which authors argue their opinion as to how OR nursing practice 'should be' constituted or developed and secondly, an overview of the research based papers which seek to examine, define or defend the role of the nurse in the OR. I have traced the development of the OR nurses' role and explored the contemporary literature which addresses the role of the OR nurse. This chapter has been divided into three sections, the first traces the historical development of OR nursing, the second, provides an exploration of trends and issues in the literature pertaining to OR nursing practice and the role of the nurse, and the third explores the research addressing the role of the nurse in the OR.

Mapping the Territory: An Overview of the Development of Operating Room Nursing

Although a definitive date for the establishment of perioperative nursing remains elusive it has been suggested that the practice of OR nursing was established in the late 1800s when surgery became 'safer' and more common and the presence of nurses in the OR was recognised as essential by medical practitioners (Gruendemann & Fernsebner, 1995; Dunscome & Riall, 1995; Kneedler & Dodge, 1991). Johns Hopkins University in the United States first identified OR nursing as a specialist area in 1889 (Gruendemann & Fernsebner, 1995). As a result of demands of surgeons for skilled surgical nurses, those nurses allocated to the OR began to specialise in intraoperative patient care separating themselves from both patients and nurses in the wards (Kneedler & Dodge, 1991). Nurses also assumed management of the operating suite further confining nurses to the OR. Thus an OR nurse role was created.

Kneedler and Dodge (1991) suggest that OR nursing practice entailed the skilled manipulation of equipment and supplies within the OR environment. Developments in the role were often marked by the introduction of surgical advances and associated technologies (Gruendemann & Fernsebner 1995; Dunscombe & Riall, 1995). The formation of distinct instrument and circulating roles occurred in the 1920s and in many ways these have remained without change until the movement toward a definition of perioperative nursing was undertaken in the 1970s (Dunscombe & Riall, 1995; Groah, 1983). The way in which the role of the OR nurse was constructed meant that the instruction of OR nurses was heavily focused on technical and instrumental skills taking place in, and around, the surgical procedure.

Operating room nursing, as a specialty area of practice, was established by nurses in the United States and thus the first professional organisation of OR nurses (Association of OR Nursing — AORN) occurred in New York City in 1949 with the express purpose of sharing knowledge and ideas (Driscoll in Gruendemann & Fernsebner, 1995). The Australian Council of Operating Room Nurses (ACORN) was formed in 1977 marking the formation of a professional organisation for OR nurses in Australia (Australian Confederation of Operating Room Nurses Constitution, 1987).

Gruendemann and Fernsebner (1995), Kneedler and Dodge (1991) and Pereira (1986) explain that central to the care of the patient within the perioperative period is the nursing process. The nursing process has been widely accepted by the nursing community and remains in use in many areas of nursing. Kneedler (1991) relates the nursing process to perioperative nursing practice and explains that it provides a logical approach to total patient care throughout the patient's perioperative experience. Pereira (1986:19-21) suggests that the nursing process provides a means of focusing the attention of the nurse on '... the patient as a person rather than an object on which to perform procedures ... the use of the nursing process in the operating room places operating room nursing on the same foundation as other areas of nursing practice' and reinforces the nursing role in the OR.

The implementation of the nursing process in the 1970s and the attempt at the redefinition of OR nursing to perioperative nursing were endeavours by OR nurses to extend their practice beyond intraoperative nursing in response to the accusation that their role was that of a technician (Kneedler & Dodge, 1991). Nurses outside of the OR '... questioned whether what they [OR nurses] did in the operating room was actually nursing' (Kneedler & Dodge, 1991:28). In relation to the position of Australian OR nurses, the OR nurse was confined to the

operating suite until at least 1977, thus effectively restricting OR nurses input into preoperative or postoperative care (Emden, 1980). The nursing process was a means of decision making derived from the scientific method to encourage nurses to provide nursing care in a deliberate and organised manner '... as opposed to haphazard care planning' (Gordon, 1982:21).

Pereira (1986:19) cites Root explaining that prior to the nursing process there existed a 'technical/behavioural imbalance in the role of the OR nurse'. Root uses the term, 'technical/behavioural imbalance' to argue that the attention of the nurse remained focused on the instrumentation required for surgical procedures and the needs of the surgeon, rather than those of the patient. The introduction of the nursing process into OR nursing practice was seen as a way of turning the focus of the attention of the nurse toward the patient and planning care in collaboration with the patient (Gruendemann and Fernsebner 1995; Pereira 1986).

Nurses in the United States of America (USA) moved toward a redefinition of nursing practice in the OR which ultimately led to the development of perioperative nursing. Kneedler and Dodge (1991) define perioperative nursing practice as '... the nursing activities performed by the professional nurse during the preoperative, intraoperative and postoperative phases of the patient's surgical experience' (1991:28). Perioperative nursing evolved in the USA in response to '... healthcare reform, technological advancements and changing opportunities for advanced practice nursing' (Ladden & Keane, 1995:1067). As a result, perioperative practice became viewed as a movement away from a 'role' within the OR to a 'practice' which surrounded the patient's operative procedures, in an attempt to shift the OR nurse's role from being technical to being person centred (Kneedler & Dodge, 1991).

In 1982 nurses in the USA developed a series of 25 competency statements to formally describe the perioperative role (Gruendemann & Fernsebner, 1995; Kneedler & Dodge, 1991). The notion of perioperative nursing now, is being seen as a way of addressing the increasing use of outpatient surgery or short stay/day case surgery (Ladden & Keane, 1995). With the advances in technology and surgical techniques and the performance of surgery in outpatient settings, the future of perioperative nursing lies in the provision of support and education in the preoperative and postoperative phases of the surgical experience rather than on the intraoperative stage (Kleinbeck, 1993). This future rests with the perioperative nurse being willing to 'abandon the status quo' and look beyond the current scope of practice to expand the horizons of perioperative nursing (Kleinbeck, 1993:908).

Nursing Practice and the Nursing Role in the Operating Room

The literature addressing nursing practice in the operating room appears to be focused on the 'ideal' in OR nursing practice, the ideal being portrayed as 'perioperative nursing' as I have discussed it (see Brown, 1995; Brougham & Berry, 1994; Holmes 1994; Marshall 1994; McGee 1994; Stephens 1994; Stuttard 1994; Kneedler & Dodge, 1991; Greaves, 1989; Pereira, 1986). The perioperative role is powerfully conveyed in the contemporary OR nursing literature. Recent OR nursing texts, such as those by Gruendemann and Fernsebner (1995) and Kneedler and Dodge (1991), describe the perioperative role as patient oriented nursing with benefits for both patient and nurse. It also is promoted as a professional role for OR nursing practice (Gruendemann & Fernsebner, 1995; Ladden & Keane, 1995; Kneedler & Dodge, 1991). Kneedler and Dodge (1991:6) state that the perioperative role '... emphasises the professional, intellectual and human aspects of

nursing and [that it] increases the responsibility [of the nurse] to the patient and his [sic] family'. Perioperative nurses are seen to possess expert technical skills within the OR, the ability to provide information and education to the patient in regard to their surgery and collect information about their condition which will assist in the preparation and conduction of operative procedures (Ladden & Keane, 1995; Kneedler & Dodge, 1991). Kneedler and Dodge (1991) also argue that perioperative nursing requires the nurses to shift their focus from the OR to the complete illness experience of the patient . The perioperative role:

... is not for nurses who prefer technical to professional activities ... nurses who do not have the inclination, warmth and the skill to work directly with patients have no place in a role emphasizing these qualities (Kneedler & Dodge, 1991:8).

Gruendemann and Fernsebner (1995) emphasise the centrality of the patient in the perioperative nursing role of today, explaining that it is 'unbounded' by geography. The authors claim that the walls of the theatre suite no longer place boundaries to 'perioperative' practice which extends to address issues of education, planning and evaluation of care with the patient outside the OR. Perioperative nursing is concerned with the planning, implementation and evaluation of patient care and is inclusive of technology management, communication with families and nurses outside the OR, collaborative decision making with medical colleagues, supervisory responsibility for assistive personnel (surgical/anaesthetic technicians) and personal development/education (Gruendemann & Fernsebner, 1995). The focus on the patient and their perioperative experience places the perioperative nurse in a position of responsibility in which decisions must be made regarding the care of the patient during the preoperative, intraoperative and postoperative stages. Thus Kneedler and Dodge

(1991) and Gruendemann and Fernsebner (1995) promote the nursing process as the means of clinical decision making for perioperative nurses which allows the nurse to plan care in collaboration with the patient where possible.

Kneedler and Dodge (1991) argue that within perioperative nursing care, patient advocacy is a vital component of practice. Patient advocacy is an issue which has received considerable attention in the literature serving to remind nurses of their legal and ethical responsibilities. Recent authors, such as Brown (1995) and Marshall (1994), base their arguments for the presence of nurses in the OR largely upon the patient advocacy role. They assert that as it is the nurse who has spent the longest amount of time with the patient in the OR and prior to surgery, it is appropriate for this nurse to act as patient advocate. To emphasise the advocacy role Brown (1995), Ladden and Keane (1995), Marshall (1994) and Kneedler and Dodge (1991), recommend that OR nurses expand their practice to include preoperative visiting. Marshall (1994) maintains that this practice would assist these nurses to carry out the advocacy role and contribute to the establishment of a trusting relationship between nurses and patients. Brown (1995) suggests however, that nurses experience a difficulty in speaking out as advocates within the existing culture of the operating room and she asserts that nurses have been socialised to be compliant, being dependent upon medical staff for authority. I feel that although Brown (1995) makes a worthwhile point, her argument is somewhat simplistic. Little mention (except for tradition) is made of the reason for the submissive nature of nurses and not once is the issue of gender raised in the brevity of her argument. Brown (1995) also argues that the successful role of the nurse as advocate in the OR is dependent on the existence of teamwork between staff working in the theatre. Greaves (1989) asserts that the nurse is an essential member of the OR team and provides a reassuring presence to the patient within the theatre suite

but suggests that the OR nurse needs to raise her identity outside the theatre suite in order to provide the necessary care of the individual patient. She claims that knowledge of the patient gained through preoperative visiting allows the nurse to enhance the advocate role. Greaves (1989) also observes the necessity for the OR nurse to adopt a perioperative perspective to effectively combine the functions of patient advocate and be a successful team member in the OR.

Many authors claim that OR nurses must adopt a perioperative role in order to develop the role in a professional manner and to provide appropriate perioperative patient care (Gruendemann & Fernsebner, 1995; Ladden & Keane, 1995; Kneedler & Dodge, 1991 and Pereira, 1986). However, a current issue facing OR nurses is the threat of replacement of OR nurses with surgical and anaesthetic technicians. Pereira (1986) suggests that the perioperative nursing role has been developed as a direct response to allegations that OR nurses are technicians rather than nurses. Much of the literature surrounding the development of OR nursing practice, especially that which looks at perioperative nursing, has come about in response to questioning the reasons nurses are required in the OR.

The increased use of surgical and anaesthetic technicians in ORs around the world has led to a reduction in nursing numbers in the OR (Brougham & Berry, 1994; Fox, 1985). Brougham and Berry (1994) propound that one reason for the replacement of OR nurses with technicians has been the difficulty in recruitment brought about by the 'phasing out' of apprenticeship style nurse training. Another reason is that OR practice is viewed by those outside the OR as 'not really nursing'. However, Fox (1985) claims that the role of the technician has subsumed that of the OR nurse and whilst the technicians have been able to define their role in the OR, the nurse continues to struggle to define her practice as a nursing role. Brougham and Berry (1994) and

Fox (1985) recognise that the survival of the OR nurse is largely dependent upon the nurse formally defining the OR nurse role. The survival of the OR nurse is of obvious concern given the promotion of perioperative nursing that abounds within the journals. However, Abbott (1994) considers the latest introduction to the OR in the United States, the Unlicensed Assistive Personnel (UAP), to be a greater threat to nursing than the surgical technician (ST). The roles of the ST's and the UAP's have usurped nursing roles resulting in role erosion.

The first section of this chapter has reviewed the literature which addresses OR nursing practice and aspects of the role of the OR nurse. This literature has consistently argued the need for OR nurses to expand the focus of their practice to a perioperative role to include all aspects of the patients' surgical experience, in this way moving outside a role which lies exclusively within the OR (for example, Brown, 1995; Gruendemann & Fernsebner, 1995; Brougham & Berry, 1994; Kneedler & Dodge, 1991 and Pereira, 1986). The perioperative role is portrayed as a means of developing the role of the OR nurse and preserving the presence of OR nurses in the theatre, whilst providing the patient with perioperative care rather than intraoperative care only. The subsequent section turns to the research-based literature which explores nursing practice and the nursing role in the operating room.

Researching Nursing: Stories told Through Research

The use of narrative to explore nursing practice in the OR is a recent addition to the OR literature. Narratives have been used by Conway (1995) and Anastasio and Foldy (1995) to explore the expertise of the OR nurse. Conway (1995), influenced by Benner's work, conducted a descriptive study examining the knowledge expert nurses use in practice. The stories of thirty five nurses in the study were explored to

identify the knowledge expert nurses possess (Conway, 1995). Conway (1995) suggests that the OR nurse combines anticipatory knowledge with the ability to be flexible within the nursing role. In addition, she argues that expert OR nurses must be able to develop their practice by combining theoretical knowledge and experience (Conway, 1995). She concluded that on a day to day basis, 'nurses in operating theatres ... were making complex decisions and drawing on extensive knowledge bases that were rarely acknowledged' (Conway, 1995:15).

Anastasio and Foldy (1995) were also influenced by Benner's work and used OR nurses' stories from practice to demonstrate the expertise of nurses. These stories of nurses' daily practice allow the nurses to evaluate their abilities and influence the practice of others whilst celebrating the '... power of expert nursing practice' (Anastasio & Foldy, 1995:58). Anastasio and Foldy (1995:56) cite Benner in order to discuss the experiential component of OR nursing knowledge, noting that it is, '... the skill of involvement [which] is crucial for developing expertise'. Anastasio and Foldy (1995) present narratives which detail two perioperative nurses experiences with patients undergoing complex surgery. The authors claim that this ability to describe clinical expertise provides a voice with which to speak of practice as 'perioperative nurses' which, in turn, provides nurses with opportunities for 'professional growth' and appropriate descriptions of nursing practice in the OR (Anastasio & Foldy, 1995:58).

By contrast, a recent study by Kalideen (1994) uses a grounded theory approach to analyse the responses of seven nurses to the question of how they would describe the motivational factors which led them to locate their nursing practice in the OR. This study also explores how these nurses viewed their initial experience, what provides them with satisfaction in their practice and how they would describe nursing in the OR. Semi-structured interviews provided the means of data

collection. From the analysis of the data, Kalideen (1994) concludes that she could find no clear motivational factors as to why nurses would locate their practice in the OR. However, Kalideen did determine that nurses practising in the OR have a strong sense of task identity and significance. The author also suggests that nurses in the OR found some personal identity through 'identifying with the team in the operating theatre, which enhanced self esteem and reduced anxieties allowing them to be integrated into the work role' (Kalideen, 1994:23). The respondents viewed the perioperative role as a means of improving the quality of patient care, developing the role of the OR nurse and increasing the visibility of the OR nurse (Kalideen, 1994). However, she reports that although nurses state believed in the importance of a perioperative approach to the care of patients undergoing surgery which is supported by the professional literature, they reported both a lack of time and sufficient staff for them to undertake a 'perioperative' role.

Using informal conversations with OR nurses from several different operating suites, McGee (1994) conducted a descriptive study to examine how OR nurses view their work. From the data McGee (1994) determines that significant issues for OR nurses were their roles as patient advocates and loss of patient individuality in theatre. According to the professional literature, nurses acting in a perioperative role would be familiar with the patient from a preoperative visit; this may reduce this tension experienced by nurses in such situations. McGee (1994) also notes that although the OR nurses were extremely knowledgeable about the procedural aspects of surgery and the associated technology, they acknowledged that there was limited interaction between nurses and patients. This limited interaction between nurses and patients has significant implications for the perioperative nursing role. The importance of team membership in the OR alongside the surgeon and the anaesthetist was also found to be an

issue of significance for OR nurses. According to McGee (1994), OR nurses felt there were two aspects to the nurses' role: the perioperative aspect which required the nurse to move in and out of the OR and the role as an educator for junior staff in the department. McGee (1994) recommends that theatre nurses clearly define their practice at both beginning and expert levels, and develop a perioperative role. However, the author's recommendations only serve to reiterate the perioperative rhetoric which states that the 'perioperative' role requires the nurse to move out of the OR in an attempt to develop practice.

As an adjunct to her doctoral study exploring nurses' perceptions of nursing care provided for patients in a cardiothoracic unit, West (1993) interviewed an OR nurse in regard to her perceptions of care provided for patients entering the OR. From this single interview she 'found' that nursing care in direct association with the patient in the OR was determined by: patient anxiety; demands on nursing time; the intensity of postoperative care; the health status of the patient; the pain experienced by the patient; the provision of information to the patient and the development of a relationship with the patient (West, 1993). West (1993) concludes that central to the OR nurse's concerns when providing nursing care was the well-being of the patient. West (1993:22) claims that her brief and limited examination of one OR nurse's practice is an attempt to broaden the understanding of the 'critics of theatre nursing [who] comment that scrubbing for operations is not concerned with patient care'. On the basis of this limited study, West (1993) defends the role of the OR nurse claiming that nursing practice in the OR consists of both technical competence and the emotional/psychological aspects of caring.

Within the nursing literature the notion of caring has been explored extensively by authors such as Benner (1988) and whilst caring has been considered within the generalist nursing population, the notion of

caring within the OR has only recently received attention within the OR literature.

McNamara (1995) conducted a phenomenological study exploring the caring role with five experienced OR nurses. The researcher developed a series of twelve open ended questions designed to stimulate descriptions of the nurses' actual experiences of how they construct and demonstrate caring practices in the OR with both conscious and unconscious patients, rather than how they conceptualised their experiences. These responses to the questions described an aspect of the role of the OR nurse. The data were arranged into themes which the author felt reflected the phenomenon of caring within nursing practice in the OR. The author claims that the major implications of this study fall into two areas of nursing practice, those of education for nurses and the management of operating rooms/perioperative services. McNamara (1995:387) determines that the exposure of student nurses to perioperative nursing enhances their perception and understanding of the effects of surgery on patients in an area in which the potential to 'dehumanise patients' is high. Regarding nursing management of the OR, this study attempts to assert the value of perioperative nursing practice and caring. McNamara (1995) concludes that caring does exist in perioperative nursing practice and nurses in this area can identify caring behaviours.

The nurses role within OR has been described within the literature as being focussed upon technical tasks with recent attempts to expand the role to address patient needs outside of the OR (Gruendemann & Fernsebner 1995 & Kneedler & Dodge,1991). Research exploring the role of the OR nurse attempts to move away from the technical view of the OR nurses' role by exploring aspects of the role not previously considered (see Anastasio & Foldy, 1995; Conway 1995; McNamara, 1995; Kalideen, 1994; McGee, 1994; West, 1993). The challenge to OR

nurses restricting their practice to the space behind the theatre doors is the impact of surgical technicians upon the traditional OR nurses role. The following section considers the literature which addresses the introduction of surgical technicians to the OR.

Researching the Affect of Technicians on the Role of the Nurse in the OR

The development of the ODA¹ role has fuelled a continuing argument over the necessity for nurses in the OR. To that end Fennell (1989) conducted a descriptive study in which she visited three teaching hospitals in London to interview OR nurses. Following the informal interviews which drew on the nurses' descriptions of their practice, the researcher concludes that the data demonstrated that OR nurses 'must introduce the nursing process for their own survival', and assume a nursing role which provides care in all stages of the patient's surgical experience (Fennell, 1989:16). Fennell (1989) also asserts that nursing practice in the OR as it stands is not nursing, but technical expertise, and any change to the nursing role must arise from both management and nurses willing to address significant changes to the status quo.

A further study by Roberts (1989) details the effect of the ODA on the OR nurses' role. Roberts (1989) conducted a survey by questionnaire identifying aspects of the role of the OR nurse and associated working conditions in order to discover what OR nurses thought their role should be. The results demonstrated that OR nurses enjoyed their roles as 'scrub' nurses 'the most', and aspects of the role least enjoyed were those in which the OR nurse had direct communication with, or care of the conscious patient (Roberts, 1989). Roberts (1989) concludes that the

¹ The operating department assistant (ODA) is a title adopted in the United Kingdom for a role which is similar to that of surgical technicians in Australia and the United States.

results of the survey demonstrate the OR nurse is strongly aligned with the technical tasks of handling instrumentation and equipment. She recommends that OR nurses must extend their practice beyond the OR toward perioperative nursing.

When one considers the perioperative nursing role, the findings of these studies have considerable implications for nurses who perceive their role to be restricted to practice in the theatre with minimal contact with conscious patients. I would argue that the avoidance of direct communication or care of conscious patients leaves nurses in the OR a limited position from which to argue a legitimate nursing role. I would also suggest that these nurses are in danger of having their role redefined in terms of technical support to surgical staff.

Exploring the Culture of the Operating Room

I believe the culture of the operating room contributes significantly to the perception of the value of nursing in that area. Surprisingly, only a two studies are available which discuss the culture in relation to OR nursing practice. Wood (1991) completed a qualitative study using a grounded theory approach to explore nurses' interest in and satisfaction gained by working in the OR. The researcher interviewed ten OR nurses and discussed the findings which explored issues such as OR nursing practice and the OR culture. The results of the study served to demonstrate that there was an expectation for OR nurses to develop considerable expertise with technology, whilst adapting to the culture of the operating room, which includes isolation from nurses outside the OR. Wood (1991) argues that nurses in the OR are imbued with a sense of task identity for their work and conform to the procedural regimen of the theatre complex. As with many other studies contained within this review, the recommendations are for the OR nurse to

expand her role to undertake that of the perioperative nurse. Wood (1991:10) suggests undertaking a perioperative role may help dispel 'the myths surround OR nursing and increase the visibility of the OR nurse'. Once again the researcher appears to recommend the perioperative role as the only answer to expanding and developing the restrictive practice of the OR nurse in which the role is constructed as a technician working with unconscious patients.

Wood's (1991) examination of the nursing culture in the OR, is built on by Fisher and Peterson (1993) who conducted a qualitative descriptive study using interview and participant observation data collection methods over a five month period with staff working in the OR. Although seeking to address the issue of surgical personnel and their treatment of elderly patients, Fisher and Peterson (1993) make significant comments regarding the social and political culture of the OR by exploring the control and authority of the surgeon within the operating room. The researchers also address the role of the surgeon as a role model and the affect of his behaviour upon the other staff within the theatre and in the light of his authority. The research suggests that although it is necessary for there to be control of the proceedings within the OR (a role assumed by the surgeon) there was significant influence on staff within the OR by the surgeon's mood, attitude and behaviour (Fisher & Peterson, 1993). Fisher and Peterson (1993) also found that the culture of the OR and the nature of the relationship between nurses and surgeons prevented nurses from having open communication and valued input into the care of the patient in the OR.

In summary the expansion of nursing practice from that which is specific to the OR toward a perioperative role is a common message contained within the papers addressing OR nursing practice. The perioperative role is conveyed as the 'ideal' professional OR role, providing patient care across the surgical experience and effectively

defining and articulating the nursing role in association with the OR. However, the research findings to date suggest that in reality there is little practice of perioperative nursing (McGee, 1994; Kalideen, 1994). The research studies suggest that the OR nurse remains adhered strongly to the technical and procedural tasks of the OR (Conway, 1995 ; Kalideen, 1994; Woods, 1991 and Roberts, 1989). These researchers, Conway, 1995 ; Kalideen, 1994; Woods, 1991; Roberts, 1989, also recognise that OR nurses continue to limit their practice by basing their role completely in the OR acting in a technical capacity. Studies urge nurses to establish a perioperative role which addresses patient needs across the surgical experience.

From the research findings it is evident, therefore, that the perioperative role is rarely adopted by OR nurses. The professional literature espousing the perioperative viewpoint becomes, in turn, a form of rhetoric. Kalideen (1994) argues as a result of her research that perioperative nursing may be ideal in theory but the research findings suggests that although nurses may identify the value in perioperative nursing practice few nurses adopt a perioperative role.

Within the literature the notion of the perioperative role appears to be gaining momentum, with many authors recommending that OR nurses adopt this 'ideal' role which would expand nursing practice in the OR and confirm a nursing component to theatre work by addressing all aspects of the patient's surgical experience. The research findings, however, are informed by and reproduce a dichotomy as many nurses do not practise the ideal perioperative role. In fact, the reality suggested by the research is that OR nurses appear to restrict their practice to the OR and relish their technical skills. The findings also suggest that contrary to the notion of expanding practice to interact with the conscious patient outside the OR, the nurse avoids such contact preferring to remain in the familiar technical and task oriented

role (Kalideen, 1994; McGee, 1994; Wood, 1991; Roberts, 1989 and Fennel, 1989). As a result of the dichotomy I have suggested between the 'ideal' perioperative role and the reality of a restricted technically focused role, much of the professional literature becomes rhetoric when viewed in the light of these research findings. My study explores the notion of OR nursing practice through the stories that nurses tell about their practice and the context in which it takes place, in an attempt to further understand the construction of OR nursing practice and the culture of the OR.

CHAPTER THREE: EXPLORING THE POSSIBILITIES OF AN ETHNOGRAPHIC METHODOLOGY

This study describes OR nurses' experiences of practice in an attempt to gain a deeper understanding of how nurses practise in the OR and to map out some of the cultural territory of the OR in order to acquire a greater understanding of the political, social and historical issues which impact upon the construction of the OR nursing role. In this chapter, the assumptions of the ethnographic methodology pertaining to the question driving this thesis will be explicated. I will discuss traditional ethnography and the critique recently afforded this by post positivist researchers and address the implications for conducting this research study with a critical edge.

Ethnography, Possibilities of Method

Traditional ethnography has its roots in anthropology and lies embedded in the empirical sciences which are defined by 'objectivity' and 'authority'. Ethnography is described as a written representation of a culture or alternatively, selected aspects, in which culture may be considered to be the knowledge members of a particular group are thought to 'more or less' share (Van Maanen, 1988). It is this knowledge then, which shapes, informs and accounts for the routine and not so routine activities of members of a culture (Street, 1992a and Van Maanen, 1988). As ethnography is now practised across a number of disciplines, considerable diversity exists in style and method. In traditional ethnography the written representation of a culture is informed by undertaking fieldwork within a selected culture. Fieldwork has consisted of participant-observation of the members of

the culture and interviews with selected informants over extended periods of time in order to collect data for analysis (Street, 1992a and Van Maanen, 1988). The expectations of fieldwork are that the researcher (to the best of their ability) shares in the environment, problems, lives and the social relations of a specified group of people and then seeks to represent the culture they have observed as a fixed textual document (Van Maanen, 1988). Traditionally, the ethnographic researcher's role was purportedly that of an unbiased and impartial observer and the data which were gathered constituted the 'truth' or 'fact'. The ethnographer, in the unbiased and objective role, must find a precarious balance between attempting to be a member of the culture under study and at the same time a stranger, observing and reporting with accuracy (Hughes in Bruni, 1995). The traditional ethnographer seen in this way has been influenced by science and positivistic research methods.

Contemporary writers, such as Lather (1991), Van Maanen (1988), Tyler (1986) and Clifford (1986), have challenged the basic assumptions of objectivity and neutrality through their critique of positivist methods. Lather (1991) claims that there is no neutral research, as any research into the human sciences is written from the perspective of the researcher and influenced by her past experiences. The researcher lives and interacts with the world of which they are a part, for it is impossible for us to deny our own values and produce what Rheinhartz (in Lather, 1991:50) describes as 'interest free knowledge'. The search for the one truth, a truth (argued to 'exist' by positivism in following the 'correct' research method) does not necessarily guarantee 'true' results (Lather 1991).

Lather (1991) argues that post positivist approaches to research seek to disrupt the rules and boundaries which have previously constrained research. Further, as Parsons (1995:22) argues, these methodologies may

allow deeper understandings of contextualised behaviours or meanings which are grounded in 'everyday' life moving away from the randomly sampled populations from which research findings are said to represent the attitudes and behaviours of the majority. Post positivist research methods then may 'work in ways that open up the possibility for unsettling the complacency of subordinated and marginalised groups such as nurses' (Robinson, 1995:67). Postpositivism then, challenges the conventional rules of methodology recognising that there is no singular thing as 'truth' waiting to be discovered and reported. Mishler (cited in Lather, 1991:52) explains that this shift in thought has resulted in a, 'constructive turmoil which allows a search for different possibilities of making sense of human life, for other ways of knowing which do justice to the complexity, technicity and indeterminacy of most of human experience'. Therefore, my own positions as researcher and as an OR nurse are inherent in the interpretation and representation of the data in this study. The study represents one interpretation of these stories, and in no way do I make a claim to 'truth' but rather, I seek to provide descriptions of OR nursing practice whilst raising some of the hidden cultural issues which serve to shape and, in turn, be shaped by OR nursing practice.

Ethnography as a methodology now reaches beyond the simple textual claims of the representation of culture and considers not only the 'contexts of power, resistance, institutional constraint, and innovation' but their influences in the constructions of the representation (Clifford, 1986:2). Culture shapes, and is shaped by, the individuals within it. The affect of culture upon our experiences and practices has led me to explore OR nursing practice in a contextual way which maps out some of the culture of the OR and explores political, social and historical issues embedded within it.

Movement away from the traditional ethnographic method has led to the establishment of critical ethnography:

A critical approach aims to expose, identify and challenge the understandings of reality in order to reveal to individuals that their beliefs and attitudes may be ideological illusions and distortions that actually work against them (Beattie, Cheek & Gibson, 1996:684)

Lather (1991) describes this form of inquiry as providing emancipatory knowledge which seeks to increase the awareness of contradictions present or those invisible to our everyday understanding and allows us to direct our attentions towards the possibilities for social transformation which may be present in the social context.

The use of ethnographic methods in exploring health and illness through nursing is perhaps still in its infancy with Leininger making the initial inroads with the use of traditional ethnography (Bruni, 1995 and Robertson & Boyle, 1984). However, there appears to be an increasing use of critical approaches to more fully describe aspects of nursing culture and practice (for example Walker, 1993; Street, 1992a and Lawler, 1991). This focus upon nursing practice and culture enables nurses, as well as others, to understand not only what nurses do and why they do it, but also to acknowledge the powerful historical, political and social factors that help to shape their work.

Telling Stories, Truth, Language and Subjectivity

If experience is understood through language, and language shapes how we see and act with and on the world, then it follows that experience does not guarantee truth since it is always open to conflicting interpretations. That is, our experience is not some fixed or fluid essence, or some concrete reality that exists prior to language, waiting to be reflected by

language. Rather, experience is constituted by language (Weedon in McLaren, 1988: 4).

The knowledge produced in this ethnographic text is partial and incomplete, and the stories do not represent an '... untarnished image of reality' in the OR (McLaren, 1988:4). Instead, they represent the nurses' particular understandings of the world which, in turn provides them with particular meanings to ascribe to their experiences. Meanings and interpretation of our experiences within the world in which we are a part, are dependent on the discourses available to us at any particular time (Weedon, 1987). I am therefore, describing the understandings OR nurses have of their experiences and interpreting these understandings.

As we embrace the practice of language as individuals, we ascribe meaning to our experiences. Our understandings of these experiences are influenced by particular ways of thinking and doing, differing discourses, in this case the powerful discourses of medicine and nursing. These influential ways of thinking and doing (discourses) constitute our consciousness which, in turn, informs our perspectives of who we are and how we are positioned within the world. This consciousness determines our sense of our self and thus our subjectivity (Weedon, 1987). I am not therefore, claiming these experiences as truth but rather I am suggesting that the stories told, through language, illustrate how we see, are shaped by and act within our world.

My choice of a critical framework for my study as informed by the literature, raised for me the issue of the relationship between researcher and participant. The traditional 'researcher-subject' relationship creates a power differential with the researcher having power over the subject. The researcher may exert this position of power to influence the depth of contribution of the participant. My intention

was to pay close attention to the establishment of a 'flattened' relationship. I felt that I wanted to create an atmosphere of storytelling with the nurses as opposed to interviewing. Thus, Lather (1991:57) speaks to the notion of reciprocity in which the attention paid to the relationship between researcher and researched, is a 'matter of both intent and degree': She argues that, 'the researcher moves from the status of stranger to friend and thus is able to gather personal knowledge from subjects more easily' (Lather, 1991:57).

In considering the conduction of his doctoral research Kim Walker (1993:26) claimed that he did not want the women he was engaged in research with to think of themselves as 'Kim's group'. Like Walker (1993) I did not want the participants in my study to think of themselves as as 'Jill's' group'. However, we cannot deny and indeed we must accept, that our positions as researchers have some affect on the research. I was concerned about my position as the researcher, but I felt that I had addressed this issue as fully as possible and accepted my role as author of the research document.

Encouraging the Speaking Subject

Language provides us with a way of articulating meaning to represent specific values and interests (Weedon, 1987). Language forms competing discourses which commit the individual to specific subject positions. Within the OR the dominant discourse remains that of medicine even as one considers the rise of management and economic discourses. It follows then that nurses occupy subject positions which create nursing roles as they pertain to medical interests. Thus nurses consideration of language, its construction and indeed the ways in which discourses may be used may provide a deeper theoretical exploration of 'the way it is' in the world of nursing practice (Bruni,

1995). One of the reasons for exploring the voices of nurses in the OR is that the powerful medical discourse is said to silence the nursing voice (Parker & Gardiner, 1992). The legitimate voice is the voice of medicine, and certainly the voice of the nurse may become subsumed by this discourse.

The voices of women within literature and the experiences of women in society are often silenced by the patriarchal culture of which we are a part. Thus, the voices and experiences of nurses/women are often also silenced by medicine. hooks (1989:124) identifies the silence of women as the 'right speech of womanhood the sign of woman's submission to patriarchal authority'. hooks's quote recognises the silence of women in the presence of men as being 'right' in our society, the 'way things are'. Having identified this silence within the literature the issue of soliciting women to speak, let alone speak in an 'authentic' voice, is a difficult and challenging move (Ellsworth, 1992:104 -105). Speaking in 'authentic voices' then, means not only to 'uncode' or change the *way* things are said by women, it means to challenge the power relations and expose oneself taking in hand '... the issues of trust and risk' (Ellsworth, 1992:105). Seeking this 'authentic' voice, I set out to create a space in which nurses might tell their stories in a way that reflected their day-to-day experiences and, at the same time, which gave them permission to question and challenge the ways in which their practice was constructed.

Being An 'Insider' and Issues Of Authority

As an operating room nurse I am an insider to the culture of nursing and I am personally connected to the women who shared their stories with me. Within traditional ethnography the notion of the researcher being a 'native' in the culture to be studied is frowned upon.

Hammersley and Atkinson (1983) and Rosenthal (1987) stress that vital components will be missed due to the familiarity of the setting. However, what Clifford (1986:9) claims to be 'different rules of the game' are emerging within ethnography as the 'indigenous ethnographer' (the ethnographer from within the culture) emerges. I agree with Clifford (1986:9) as he argues for the 'insider' approach to ethnography, acknowledging that 'insiders studying their own cultures offer new angles of vision and depths of understanding'. As, a member of this group in my role as the 'researcher' and an operating nurse, I argue that I am also positioned somewhat differently to the other nurses as a result of my exposure to the theoretical musings of the authors of the literature accessed throughout the Master of Nursing degree.

Allen (1995:174) has argued that scientific objectivity has encouraged nurses to stand 'outside our practice world' and take a 'measurable and neutral stance' in the conduct of research. However, it is this objective detached scientific view of nursing that may also have helped to silence the voices of nurses by denying experiential views of the world in favour of empirical evidence. I feel that my experiences as an 'insider' belong to this study through the theoretical exploration of the data. Rudge (1996) asserts that the researcher's position within the research is never static and neither are the positions of the participants. As a researcher familiar within the culture, my position was always in flux as I moved within the research as 'the researcher' or as a member of the culture (one of the voices). Thus, the tension of these positionings remained everpresent.

Considering my agenda of bringing the stories of OR nursing practice to voice, this tension of where one's subjectivity resides is unavoidable. As a researcher, however, the process of conducting research is one of informed decision making, and, ultimately, choice. Whilst striving to

maintain the notion of participatory research in the sense of the participants' storytelling, a difficulty lay in 'knowing' and yet 'not knowing' these other nurses. Ellsworth (1992) explains that while we may know each other, we cannot know one another's experiences/knowledges.

Embarking on the Research Journey

In beginning this study I approached five OR nurses and invited them to participate in a focused group discussion through which we would share our stories. I had worked with each of these nurses and they had also worked together on various occasions within the metropolitan hospital in which we were employed; therefore, we were familiar with one another. I felt that knowing each other would eliminate a sense of newness within the group and that it would assist in the process of sharing our stories of OR nursing. The potential participants appeared enthusiastic about meeting as a group to discuss their OR experiences and consented to be a part of the research study. Rebecca, Claire, Susan, Phoebe and Sarah were all experienced practitioners within the operating suite and they were major contributors to this study.

Rebecca is a Clinical Nurse Consultant (CNC) a title which describes a senior clinical management position within the OR. Rebecca has worked within the operating suite for fifteen years, both part time and full time whilst raising her family.

Claire is a 'level one' nurse with approximately twenty years of experience across many surgical specialties. Claire has also occupied a teaching role within the post registration nursing course taught within the hospital. She currently is the senior nurse in one of the operating

theatres. Claire lives in the country with her husband and two children.

Susan is a 'level two' clinical nurse who has been working in the theatre suite for eleven years. Susan has recently shifted the focus of her practice to undertake the role of anaesthetic nurse. Susan has a passion for travelling and has recently returned from a world trip with her husband.

Phoebe is the only participant who completed her preregistration education within a tertiary institution. She is a level one registered nurse of four years experience and has recently completed a post registration course in perioperative nursing. Phoebe recently gave birth to her first child and has returned to work part-time.

Sarah was one of the last hospital based student nurses to 'train' locally and is the relative newcomer with two year's experience within the operating suite. Sarah plans to move interstate to further her operating room experience and to pursue entrance into post graduate education.

The focused group discussion as a method was selected because the stories told in focused groups may be more informative than that of other data collection methods (Carey, 1994). I believe that utilising the focused group method provides an opportunity for these nurses to tell the stories of their practice as they would tell these stories to their peers — in a safe and accepting environment. Within this method, semistructured sessions are held in informal surroundings and moderated by a group leader with the purpose of collecting information related to the experiences and beliefs of the members of the group; as such members, are often selected on the basis of their common experience (Carey, 1994). The nurses within this focused group were all OR nurses with at least two years OR experience. As the size of the

group may influence the comfort of members (a smaller group being less confronting and, therefore, enabling group members to speak more 'easily'), a group size of between four and six was considered to be appropriate (Carey, 1994).

The time and location of the meetings were a collaborative effort from the start and we agreed to meet at a time and in place which would be mutually convenient. We planned each of the focus group sessions to be of approximately two hours duration over four meetings. A period of two hours allowed us to ease into a session of discussion with what Carey (1994:230) refers to as 'pre-session chatting' which served to break the ice by settling ourselves with coffee and cake. A series of four focus group sessions allowed the participants to become more comfortable about sharing their stories. Each session was audio-taped and following each focus group session, direct transcriptions were made of the group conversation. These transcripts (in full) were then used to feedback to the next group session as in this way there was an opportunity for the members to clarify the content or raise issues from it. However, it appeared that the participants did not consistently read the transcripts, but this omission did not seem to affect their willingness to continue the conversation. I read and re-read the transcripts for a sense of underlying issues and cultural practices and to assist me in raising issues for the next meeting.

After the final focused group session was transcribed, I read transcripts of each session thoroughly whilst simultaneously listening to the tape of the conversations to more clearly understand the issues within the contexts of these conversations. It became clear to me that over the course of the sessions a pattern of story telling had developed which reflected two major narratives. In theorising these stories and raising issues I have drawn on work of some of the researchers who have recently written of the cultural, social and political issues which

surround clinical nursing (see Cheek & Rudge, 1994; Walker, 1993 and Street, 1995, 1992a & b, 1990).

Ethical Concerns of the Methodology

A copy of the information sheet was provided to each of the nurses invited to participate in the study. This sheet contained information about the purpose and conduct of the study and I spoke to each of the nurses for clarification of these concerns. Utilising a focused group method to collect the stories carries a risk of personal exposure that one or all of the group may later regret. At the time of signing the consent to participate in the study, participants were invited to share conversations at the level to which they felt comfortable. They were told that they could withdraw from the study at any time and for any reason. The participants were assured that the transcripts and audio tapes would be kept in a locked filing cabinet in an office of the Tasmanian School of Nursing for five years. They chose pseudonyms to protect their anonymity and received the transcripts from each session.

On completion of the series of focused groups I offered the opportunity for the participants to speak to me in a 'one-to-one' interview situation, providing an occasion to share particular stories that they had not had the chance to do. Only one participant chose to avail herself of this opportunity, the conversation was audio taped and transcribed.

The stories told by these nurses unfold in the following two chapters through my interpretation and theorising. The first of these explores the understanding the nurses had of the role of the OR nurse, whilst the second tells of the experiences they have had as nurses within this complex and hierarchical culture.

CHAPTER FOUR: CONSTRUCTIONS OF OPERATING ROOM NURSING — EXPECTATIONS AND ROLES

Many nurses probably do not think about why they are in practice in a particular area. Maybe we seek to practise in a location which we perceive will give us some sense of self satisfaction in our work. Our history of enculturation may also serve to strongly influence the decisions we make in regard to where we might want to practise. In this chapter Phoebe, Sarah, Rebecca, Claire and Jill share their stories of coming to practise in the OR.

The experiences we have as students and as registered nurses provide us with views of many areas of nursing practice and from our experiences in each area we develop particular values and beliefs. It is from this background of experience and enculturation that our knowledge and understandings of practice have been constructed. These opinions we hold may then assist us to determine the 'more' or 'less' desirable locations in which to practise. Wood (1991) and Roberts (1989) found that interest in the OR often stems from a student placement in the OR. Indeed, most of the group's interest was cultivated from such a placement. Each of us had expectations of how nursing practice in the OR would 'look' or why we felt that practice on the general wards was not what we wanted. I asked the nurses in the group to share their stories of how they came to be working in the OR and to talk about how they understood their role. In this chapter I have privileged certain stories from the group for the purpose of illustration of the issues. In doing so I have omitted Susan's voice. I did not set out to highlight voices of individuals in this study.

A Special Place to Practice

All but one of the nurses participating in this study trained within the traditional apprenticeship model of nursing education in which theory was located within the classroom and practice at the bedside. The knowledge imparted to us within the classroom was reductive in nature, and we 'learned' the body in discrete systems which were taught by the medical practitioners who 'knew best'. Medical knowledge which is based on science was then imparted as legitimate knowledge. The nurse's role in the use of this knowledge was revealed to be a series of tasks to support and facilitate the healing process of the patient and perhaps, more importantly, the nurse's role was seen to be carrying out the instructions of the physician. The acceptance by nurses of this 'natural' hierarchy within the healthcare system leads us to embrace the superiority of those who hold knowledge of science, technology and medicine (Street, 1992a).

In the focused group I shared with the group the reasons why I chose to practise in the OR. My own desires in regard to my nursing practice may serve to be telling of nurses' relations to medicine and science and the legitimacy sought through these knowledges.

Jill: In the third year of my training... and it's funny this seemed to come more in the third year of my training in the hospital... that I didn't just want to be a ward nurse... and my concern was that I would be labelled as stupid or inadequate if I was only a ward nurse... you know... could only do ward things... and so I was looking for a specialty, where I could maybe be valued a bit more and thought of as having a brain... and... it's a really horrible thing to say but [I was] really concerned about... how I might have looked... I just

wanted to be seen as being intelligent and being useful and being a good nurse...

Claire: *What gave you the impression that ward nurses were so... denigrated?*

Jill: *Probably the fact that basically ICU [intensive care unit], theatre, DEM [department of emergency medicine], were sold [to me] as being you know... you were a good nurse if you went to theatre, you were high tech... you were different... you were intelligent... you could cope with... the stress, you were on the cutting edge of technology stuff...*

My own nursing training demonstrated to me that the healthcare system is established on a hierarchical (and patriarchal) model which privileges the position of medical science and technology over other ways of knowing about the world. As such, ingrained modes of thought and our social, political and historical positioning as women/nurses allow us to accept medical knowledge as superior to our own. Certainly, the education I received from medical practitioners was taught within a way which confirmed my suspicions of the hierarchy of these knowledges. I believe then that nurses are often thought of by the medical establishment (and often nurses themselves) as having considerably less knowledge and status than their medical counterparts and may seek ways in which to achieve greater self worth and self esteem by closely aligning themselves with science, technology and medicine. As Walker (1994) has proposed, the powerful discourse of science constitutes nurses' concepts of themselves as nurses and their understandings of their social world. In order to construct nursing practice in a way which may be viewed by both nurses and medical

practitioners as worthwhile, nurses may seek, in some sense, a partnership with science and technology.

Wood (1991) and Roberts (1989) have suggested that interest in theatre nursing may often be cultivated during student placement. In this story fragment it is evident that I had decided, following my student placement in the OR, that being a ward nurse would label me as less intelligent than a nurse who located her practice in a highly technical area such as the OR. I believed that in the ward area there would be less opportunity to work with technology and develop the knowledge associated with such technology. By aligning myself with the challenging, exciting, complex and technical specialty of OR nursing, I viewed myself as being a 'better' nurse, a 'good' nurse, a nurse with knowledge and skills which I valued more than the skills demanded of nurses on the ward. By aligning myself with this medicalised world, defined by science and technology I placed myself in a elitist position when comparing locations of nursing practice and excluded nurses from areas outside the OR, declaring them to be of less worth. Wood (1991:9) recognises that OR nurses either 'consciously or unconsciously erect fences to protect their uniqueness'. My knowledge as an OR nurse was certainly different to the nurses who practise on the wards, and was afforded certain status and privilege by virtue of its highly technical nature. These things were made 'obvious' to me when visiting the ward on various occasions. The nurses deferred to me in their knowledge of the surgical procedures and the care the patient required in the postoperative phase. Within the literature authors such as, Kalideen (1994), Wood (1991) and Roberts (1989), found that OR nurses valued the technological skills and knowledge associated with their work as it provided the OR nurses with knowledge unique to the OR.

Whilst speaking to the legitimation that scientific knowledge affords nurses in the OR, it appears that there is a prestige with practising in

the space of the 'cutting edge' technology to which I refer. Walker (1993) notes there is a certain kudos associated with positioning ourselves alongside that which may be considered privileged knowledge, that is the knowledge of science. Further, he observes that:

the nurses in the ICU [intensive care unit] conceive of themselves as almost peers to their medical colleagues because possibly nowhere else do the boundaries and limits of what constitutes practice, the objects of which nurses speak, and what constitutes legitimate (scientific/nursing?) knowledge, blur and merge, as much as they do in the geo-political space of the ICU (Walker, 1993:134).

Although Walker (1993) is speaking of the ICU in his observation of the boundaries between nursing and medicine, I would suggest that nursing in the OR may be conceived as somewhat similar to nursing in the ICU. Within the OR, nurses and medical staff all wear a similar uniform and utilise the resources of the same technologies to practice in a way which achieves the desired outcome, shared by nurses and medical staff, the completion of the surgical procedure. By working in an area of high technology which positions the nurse alongside the doctor, the intelligence that is associated with the practice of medicine and thus the status conferred on medical staff may be in some way bestowed on the nurse who practises in a similar way. I was seeking a location for my own nursing practice in which I could be seen to be more 'intelligent' than the nurse on the general wards. I perceived that the kudos and status within nursing culture was assigned to nurses who worked within areas containing amounts of 'high tech' equipment, places such as the OR. As I settled into the OR I believed my craving for recognition was realised.

Considering his observations about nursing in spaces such as the OR and the ICU, Walker (1993) argues there is more at stake than merely the kudos which is gained by practising in places such as these. He

refers to the high level of technological skills and functions in OR nursing practice which may confuse the boundaries (on the surface at least) between the roles of the medical staff, technicians and nursing staff. Indeed, the question of whether OR nursing is in fact nursing practice, has been leveled at OR nurses (Fennell, 1989; Roberts, 1989; Fox, 1985). At times the practice of the OR nurse may be difficult to distinguish from the function of, for example, a technician. In this way the visibility of nursing in theatre is lost in an area which contains so much technology.

A brochure produced by the OR nurses' professional body, ACORN, seeking to attract nurses to the OR, pictures the OR nurse alongside the surgeon and seemingly inextricably involved with technology. The brochure also labels OR nurses as a 'special group of nurses'. I would suggest that in order to serve our own interests, nurses have perpetuated the myth of attaining power and status through seeking a closer association with medicine and technology. The message conveyed through the pictures within this brochure represent the challenges, knowledge, skills and the intelligence to master these technologies and become a part of the team is inferred. These messages are supported by the literature which describes nursing practice in the OR as: unique, challenging, powerful, 'high tech', exciting, exacting, complex and technical, certainly an enticing invitation for nurses (see Stephens, 1994; Brougham & Berry, 1994; Wood, 1991 and Davidhizar & Bowen, 1991).

The desire to work within a highly technical environment alongside medical practitioners in the OR infers the notion of teamwork in a closed environment. In the following section Sarah describes the ability to work within a team as a major attraction for her to practise in the OR.

Being Part of the Team

The notion of belonging to a cohesive team is identified in Sarah's story of why she came to the OR. The concept of teamwork is also raised within the literature, and is identified as being integral to the successful running of the OR (Brown, 1995; Davidhizar & Bowen, 1991; Greaves, 1989). Sarah was placed in the OR as a student several times during her general training and identified with the notion of teamwork as that which attracted her to working in the OR as a registered nurse. In this narrative fragment Sarah discusses her desire to be part of the theatre 'team':

Sarah: I'm fairly similar to what you said [Jill] in that... the areas like ICU, CCU and DEM... and neonates...[neonatal intensive care unit] and theatre [were seen to be important areas to work in] I always really enjoyed [theatre] in my training... when I went there... but I can pin-point the reason for this... the reason was that you were treated as a team member... you weren't the nurse, and the doctor and the physio. I mean in those specialty areas everyone is equally important... they're a team... you've got your job and... responsibilities... you're given a bit of credit... for some... instinct whereas on the ward... the majority of the time I worked there [you weren't]...

Sarah speaks of the notion of integrated teams in areas of strong medical presence and technology, such as the OR. By recognising that each member of the team is 'equally important', Sarah alludes to the team as an homogeneous entity in which the nurse's role is valued and crucial to the success of the surgical procedure. Sarah also states that being given 'a bit of credit' for what she describes as 'instinct' is

important to her. I would suggest that this 'instinct' she describes may be the knowledge and skills she has acquired within the OR, and which she feels are appreciated by those around her, the other members of the team. The appreciation of Sarah's knowledge and skills by others may provide her with a sense of satisfaction in her work in the OR. The nurse's sense of satisfaction was noted by Kalideen (1994) and Wood (1991) when they considered the role of the nurse in the OR. Sarah continues to discuss the theatre team and later in the conversation she comments on what she believes to be the team approach to problems with surgical staff in the theatre:

Sarah: If the things that they're [surgeons] doing... you have a problem with... you can address it then and there normally... for one the patient is asleep... more often than not and you can actually say something... you don't have to ask them to come outside... you can actually address it [the problem/issue] then and you normally have the back up of your level 2 [nurse] or the other staff in the theatre... might be the anaesthetists... they're quite good and quite honest when someone oversteps the line they will say, 'Well yes he did do that', or whatever... they don't seem to mind getting involved... but I find that I've always believed that I can get that support...

In the narrative fragment above Sarah alludes to the level of support she feels that she receives from team members when confronting certain problems which may arise in the individual operating theatres. Sarah's notions of dealing with problematic issues within the theatre team allude to a form of shared governance in which some balance in the team is achieved in regard to the responsibility for the patient and the conduction of the surgical procedure (Fisher & Peterson, 1993). As for the OR team, Sarah implies they are an integrated unit, and as such

are able to address conflicts as they arise. However, she contrasts the notion of an integrated team in the OR with the differences she identifies when working on the wards.

Sarah: You don't work with other staff members [on the ward] . You work on your own... and if you need help you team work then... but it's essentially you with your [patient] load... in theatre there's one patient to you know... one patient to four of you [nurses] so you actually do coexist with other nurses which I think... from my experience on the wards nurses are very individual workers... used to their own load... their own patients... their own thing.

The difference Sarah experienced between practising in theatre as opposed to the ward confirms Sarah's value of the team approach to theatre work. In exploring Sarah's notion of teamwork in the OR, I believe that she recognises that she is a valuable member of the team. Recall her comment '*you are given a bit of credit*' as she refers to the view of the medical staff toward the OR nurses. It seems to me that working within the ward environment was not as satisfying and fulfilling for Sarah as she did not seem able to identify a sense of team structure. However, from Sarah's comments on the issue of being part of a team, it appears that working within what she perceives to be 'team' environment of the OR is able to provide her with some sense of satisfaction. Sarah found that her expectations and understandings of teamwork in the OR were met in a recent experience of practice:

Sarah: The other week... on a Saturday we had an organ harvest [organ retrieval - removing the organs from a donor individual] in the morning which is something that isn't usual... it always happens at

night... they [management] called us in at ten at night but they [surgeons] didn't start till six... and the team that came over... from Melbourne were absolutely amazing... they [surgeons] were so respectful and polite and professional... very professional during [the procedure] but if you needed to ask them something that was fine... the [transplant] coordinator would come over and actually go through it with you after you had handed across what was needed... he'd come over and say why that was happening and... you know... during the tense moments, with especially in the cardiac side... he [the transplant coordinator] was just everywhere explaining it to us because all of the staff that were on that morning had never actually been there for one all the way through so... it was really, really good... and at the end... the cardiac sister came up and asked if it would be all right if they used our tea room to have a coffee while they were waiting... all of them basically lined up, and there were five consultants [surgeons] and then each had a registrar or something with them... they all lined up and they individually thanked everyone of us... in fact some thanked me twice before they went out... and then Jeff... who was coordinating... came up and had a talk to me about the actual harvest... whether any of us had been to one before and said... 'if you have any questions please contact me'... and you know... 'your help was really appreciated and if there are any repercussions with the family or... or staff members...' because he had acknowledged that they would all be leaving... and leaving us with a body... without organs... and I don't know... you seem to feel like that sort of thing... it's weird... they were all leaving

[transplant team] before we got to that stage and they said... 'if anyone has any problems or difficulties please contact us and we'll be in touch...' and 'thanks guys...' and that was it... absolutely amazing...

Recounting this experience, Sarah expressed her amazement at being a part of such a coordinated and integrated team. In this episode I believe that Sarah felt as though her skills and knowledge were appreciated and her role and input were of value in this particular instance. The way in which Sarah speaks of the surgeons as *'respectful and polite and professional'* suggests a somewhat flattened hierarchy in which the nurses find themselves identified and accepted into a team, rather than being marginalised and treated as 'other' to the power of the highly visible medical personnel and technology in the OR. Sarah's story implies how nursing practice in the OR *can* be with clinicians from both medicine and nursing not only working alongside each other, but aware of the expertise provided by each practitioner in the provision of a service for the patient. This story also serves to support claims by Kalideen (1994), Wood (1991) and Greaves (1989) that the nurse is a crucial member of the theatre team.

Getting the Job Done — Being Task Centred

Recently, Street (1995) wrote about nurses' attitudes toward their technical competence, noting that during her research she encountered nurses who were excited about their technological expertise. Indeed authors such as Kalideen (1994) and Wood (1991) argue that nurses in the OR value their technological knowledge and skills and that theatre nursing by its very nature provides a strong sense of 'task identity'. It is this 'task identity' (in that each OR nurse within a specific surgical procedure has a role to fulfil) that may be so attractive to theatre work.

In the exchange below Pheobe and Claire discuss what it was that attracted them to practise in the theatre in the first instance and share these stories with us. We pick up the conversation after I had asked Phoebe if her need to practise in this area was perhaps due to theatre work being to some degree, routine.

Phoebe: Yeah perhaps... and I think perhaps it's also having control over what you're doing... not just feeling that you are... you know... just at the doctors' whims or whatever... having to do this and that and whatever to a patient... there are certain parts that you have to do... but you can do them in your way... the way you want to and get it done as long as you achieve... you know the result... the end of the operation... perhaps it's that sort of control that's attractive to me... it's hard to put into words... responsibility to do your job I suppose is what I'm trying to get at... you know... taking it upon yourself to do what needs to be done...

Here Phoebe speaks to achieving results and the responsibility to set in motion the requirements which will ultimately support the end point of the surgical procedure (which for the OR nurse is when the conscious patient is transferred to the recovery room). This focus on achieving the result was the aspect of theatre work Phoebe identified as attracting her to the area. Her focus on achieving the 'result' finds her identifying strongly with task orientation and the ability to complete a task. Kalideen (1994) argues that the strong task identity of theatre nurses is as a result of the significance of the task as understood by the nurse. Kalideen (1994) also argues that task identity is tied to the importance of the task in the lives of others (patients) by providing the nurse with responsibility for both the task and the patient. Thus, the completion of the task and having some sense of control over being

able to 'finish' a task before moving on is important to Phoebe in her practice and has served to locate her in the OR where the emphasis is on completion of surgical procedures. The concern with the strength of task identity in the work of the OR nurse is that the patient seems to be lost in the focus on the task and the end result of completing the surgical procedure. Any notion of the 'perioperative' nurse who considers the patients' experiences across the surgical encounter is also negated by the focus on 'getting the job done'.

Claire moved to the OR so she could feel a sense of satisfaction and completion in her practice. However, she identified a lack of resources as the reason she disliked nursing on the general wards. Claire explains:

Claire: ... you have specific tasks in theatre and you either do them or not... in that you cannot start an appendix without instruments... so you've got to do a job... if you start it you get it finished and whether it costs you overtime or not is immaterial... at least when you go home you have achieved... whereas on the ward you never looked after a patient properly because you never had enough time, you didn't have enough staff, you didn't have enough equipment...

To Claire, the patient is objectified as the 'appendix' and as a 'job' and the experience of the patient becomes the achievement of the OR nurse in that the 'job' has been done and 'the appendix' removed. It is though, the task identity and achievement of results which Claire identifies as her need to practise the OR and her understanding of the nurse's role within this area. Thus, it appears that identifying with the task and 'getting things done' provides the satisfaction Claire experiences in her day-to-day work in the OR.

Contesting the Boundaries — Opening the Space Through Perioperative Nursing

As one of the more senior OR nurses in the group, Rebecca valued a role which she under took early in her career and which compelled her to locate her practice in the OR. This role allowed Rebecca to move 'in' and 'out' of theatre with patients as they experienced their surgery. I believe that the role Rebecca experienced is similar to the descriptions of the 'perioperative' role written about extensively within the literature. Rebecca was the only nurse in the group who spoke of a 'perioperative' role in any way. Let us turn to how Rebecca described her experience within this role.

Rebecca: I feel that I worked in a very privileged situation in Melbourne... I worked for one of the plastic surgeons in private [practice]... in his rooms... I saw the patient when they came into the rooms for preassessment... I was [there when] all of the arrangements [were] being made [for surgery]... I was photographing them [the patients]... I visited them in hospital either before... or at least one time during their stay and then I looked after them in the post recovery phase in the rooms... and I assisted in the theatre... that's the ideal.

Rebecca's description of the her role as an 'ideal' one for the OR nurse agrees with the descriptions of a perioperative role described by Gruendemann and Fernsebner (1995), Ladden and Keane (1995) and Kneedler and Dodge (1991). Rebecca speaks with enthusiasm for this role and labels it as an 'ideal' way in which to practise OR nursing. Rebecca agrees with the authors' views and believes that the 'perioperative' role is beneficial for the patient and the nurse as it

creates an opportunity for greater sense of responsibility for the patient on behalf of the nurse and promotes a rapport between patient and nurse. The interaction Rebecca had with the patients before and after their surgery, as well as her input into the surgical procedure appears to have provided her with a sense of satisfaction in this role. Gruendemann and Fernsebner (1995) and Kneedler and Dodge (1991) support Rebecca's views explaining that the 'perioperative' role provides the nurse with a deep sense of satisfaction for her work. I would further suggest that acting in this role Rebecca also found her responsibility for the patient increased as a result of her greater interaction with the patient and the family. The interaction would have enabled her to develop some sense of 'knowing' the patient (and perhaps the family) to an extent which is unusual in theatre work. The OR nurse usually does not meet the conscious patient nor often have the opportunity to interact with the patient.

Rebecca considered her previous role, in the story above, to be 'ideal' and moved on to discuss her contemporary practice within the OR. In her current role as a Clinical Nurse Consultant (CNC, a middle management position within the OR) she describes how she attempts to integrate aspects of a 'perioperative' role into this position:

Rebecca: *Well, I can understand the perception of theatre as being a closed environment and I think I've done a reasonable amount to opening up the communication channels with the wards... the urology ward I go at least on the odd week and chat with the people... and it's made for a much more open relationship... and with the new CNC [clinical nurse consultant] of neuro [neurosurgical unit]... I spoke to her when she took up the role and asked her if she would encourage the nurses to come up to theatre... and*

I like that... it's not always possible on other wards... neuro is relatively easy because the cases are long and if you're looking after this patient you're not necessarily needed so much on the ward and you can get to theatre... but it certainly makes a difference... I try and get to the plastic [surgeons'] rounds but that's about the only thing I can think of to make sure that I go to the wards...

Here Rebecca describes her attempts to 'open' up the doors of the OR and encourage communication between herself and the nurses on the ward in her capacity as a nurse in the theatre suite. I believe that she recognises a need for communication between the OR and the ward area as the nature of the perioperative role is to facilitate the patient's experience of the surgical procedure (Gruendemann & Fernsebner, 1995 and Kneedler & Dodge, 1991). Rebecca continues:

Rebecca: *You do get to know patients... especially when you go down to see them it makes a difference to your feelings about them... like... if you don't pre-op visit them they are the aneurysm' [abdominal aortic aneurysm].. or they are the toe nail [excision of ingrown toenail] or they are this that and the other... if you pre-op visit them you feel much more on a personal level and you know... some of those people I have pre-opped...[pre-operative visit] I've built up a relationship fairly quickly... some of them in urology where you've got patients coming back for repeated [surgery]... quite short cases... you still to know them... their names, a little bit about them... what they look like and you're able to build up a relationship that way...*

Rebecca continues to discuss aspects of the perioperative role by stressing the importance of preoperative visits for the patient on the ward. These visits not only assist the OR staff to provide appropriate patient care for the patient during the procedure, but also may enable the nurse to establish a rapport with the patient whilst providing and collecting information (Brown, 1995; Gruendemann & Fernsebner, 1995; Marshall, 1994; Kneedler & Dodge, 1991 and Greaves, 1989). The information collected by the nurse in the preoperative visit assists the nurses in the theatre to care for the unconscious patient. The visit may provide information which assists the nurse to position a patient who complains of an arthritic hip. In her descriptions of the way in which she is able to adopt a perioperative nursing role, Rebecca recognises that this role is not only important for the needs of the patient, but it allows her to raise the visibility of the OR nurse to the patient and other nurses (Kalideen, 1994). As Rebecca points out, without the preoperative visit the OR nurse is more easily able to classify a patient by their disease, symptom or case (Kneedler & Dodge, 1991). Here she recognises that without a preoperative visit the patient may assume the identity of, *'the aneurysm... or they are the toe nail...'* which effectively depersonalises the patient and results in the nurses in theatre viewing the patient as a procedure rather than as a individual (Fisher & Peterson, 1993). Of the nurses in the group, Rebecca is the only one to speak to the notion of 'perioperative' nursing. It appears that this way of practising OR nursing is not seen as being 'ideal' by the other members of the group. In this chapter it appears that the 'perioperative' nurse role is not viewed as being the way in which they want to practise nor does it appear to provide the reasons for the nurses locating their practice within the OR.

The stories told in this chapter illustrate the ways in which Jill, Sarah, Phoebe, Claire and Rebecca were attracted to OR nursing. It appeared to be the case that OR nursing roles have provided each of them with a

sense of wanting to belong, a sense of worth and a sense of satisfaction in regard to their practice. However, as we shall see from the stories in the chapter which follows, all that glitters is often not gold, and the reality of nursing practice in the OR is revealed in a variety of ways which are different to both the stories told in this chapter and the claims the literature makes in regard to the role and practice of the nurse in the OR.

CHAPTER FIVE: EXPERIENCING THE ROLE OF THE NURSE IN THE OR — THE OBJECT BODY AND THE PERSON

Sarah: I remember the first time I went into the cardiac theatre I was standing there, I'd come from 4 North and I was looking at this man that I had admitted and educated and done the whole lot... and I'm looking at him and I'm thinking 'Oh yeah'... then I'm looking over the [anaesthetic] screen into his chest... and it's this square and I'm concentrating on that ... and I found it was very interesting... but being in a spot that I was looking at both... I found it really bizarre... I didn't know who I should be... I'd worked in theatre before and so I was thinking that this is the cardiac surgery and I'm very interested in what they [surgeons] are doing... but then I kept looking at this side and thinking 'Oh Mr. Jones, what are they doing?'... it was weird ...

The nurses in this study speak to the tension that exists between 'being there' for the patient in the OR and supporting the surgical team in 'getting the job done'. Sarah's words introduce the notions of 'object body' and 'the person' and the dilemma that is created by both the nature of the work and the culture of the OR.

The stories revealed in this chapter tend to relegate the 'ideal' images of description ('perioperative' nursing) within the professional literature to the status of rhetoric. In this chapter, I attempt to flesh out some of the 'reality' of nursing practice in the OR, whilst recognising the

cultural politics and social mores which also serve to construct OR nursing.

Talking and Not Talking to Patients

Communicating with the patient is a 'taken-for-granted' aspect of clinical nursing practice in most locations outside of the OR. Nurses speak to, or interact with, the patients in their care in almost every aspect of care provided. As nurses in the OR we both remove ourselves from, and are removed from, the opportunity to interact or converse at length with any patient. The situation we find ourselves in is one which is largely defined by our location. Nurses working in Acute Care areas have traditionally sought to locate their practice at the bedside. As specialty areas of health have evolved, nurses have restricted their practice to these areas and have sought to develop expertise within circumscribed areas of practice.

In the following narrative fragment Claire reflects on the loss of her interaction with patients. In the previous chapter Claire states that the lack of material resources and time to care 'properly' for patient in the ward areas were reasons for her being in the OR. Here Claire identifies another issue which influenced her decision to practise in the OR:

Jill: You were speaking about coming in from the ward and you were talking about your contact with the patient on the ward... and then coming into theatre... you were saying it didn't bother you to lose that?

Claire: It didn't bother me at all.

Jill: *Why do you think that was though?*

Claire: *I don't know... because I found it [the wards] fairly unsatisfactory anyway... I mean I have vivid memories of people that obviously... interacting with them and talking to them was of great benefit to them and to me... so that... I'm not saying that it didn't exist... I'm just saying it wasn't an important enough part of my nursing... to worry me to lose it.*

In this exchange, Claire recognises that although there were times when she had memorable interactions with individuals these were not enough to enable her to remain practising within the ward areas. As nursing is supposed to be directed towards the care of individuals, as they experience health and illness, it is significant that Claire does not find her interaction with patients an important part of her work. We are usually led to believe that the patient is central to nursing work (Anastasio & Foldy, 1995). Here Claire is telling us that communication with the patient is not central to her work in the OR.

I would suggest that Claire's view of patient interaction as not '*an important enough part of [her] nursing*' may have been, in part, informed by her experiences as a student nurse and a registered nurse. A common experience as a student, was to be given the instruction to *not* talk to the patient. Talking (to the patient) is definitely not working and a busy nurse is seen to be a 'good' and 'efficient nurse' (Walker, 1993 and Street, 1992a). Claire comments on her beliefs about talking to patients:

Claire: *... I tend not to be someone who stands around talking to patients anyway... that was seen as wasting time...*

Within the traditional mode of nurse training (which was conducted on the apprenticeship model) the focus of the nurse was on service provision (Street, 1992b). Education of nurses was undertaken by doctors and the 'real' work (the demands of the nurse by the hospital) was done on the ward, serving doctors and patients. This form of education inducted nurses into conformity and a non-questioning attitude with the result that nurses were socialised into thinking of themselves as doctors' handmaidens (Meleis, 1985). In addition to the attitudes expected by nurses trained in this manner, there exists within the hospitals an historical process of socialising nurses into routines and task-based nursing practices which create in each nurse a 'busyness and a sense of obligation' (Street, 1992b:10). Claire carries with her aspects of her traditional nursing training which act to position her in such a way that she considers doing as more important than talking and communicating with patients. Indeed the 'busy' nurse is the 'good' nurse. I would suggest that in the OR Claire may have found a place in which she feels able to perform her duties as she expects (by being able to complete the task as efficiently as possible) and have, at her fingertips, the resources necessary to complete her work. Claire identifies that during her 'training' days talking was seen as wasting time and, therefore, it is little wonder that Claire places less value on her interaction with patients.

Phoebe continues the conversation around the reduced patient contact experienced in theatre:

Phoebe: *I've often felt after coming to theatre... perhaps you know... I'm not a good nurse... or I'm an uncaring person because... losing the opportunity to talk to patients didn't bother me so much... and I wasn't into the patient contact side [in theatre] I was into the scrubbing side and getting in there... I feel like you [Jill]*

were saying... with theatre, ICU and those areas and that... that it's a good place [in terms of importance] to be nursing... I just feel like, 'naughty me... how could I possibly feel like I don't really mind losing the patient contact... because I should be caring about the patient and I should want to do all this sort of thing [talking to the patient]...'

Claire: *But if you're happier in theatre, you're going to do a better job in theatre than you would out on the wards so...*

Jill: *So more of yourself goes into that role... although it might be defined differently.*

Phoebe: *Yeah, because it is doing the theatre course that has changed my thinking towards the way I feel about my contact with patients... I just think, well, yes... this is where I am... I just do the best that I can here and that's fine... that's enough. I don't have to feel you know... that I'm inadequate or not a good nurse...*

Jill: *Yeah... so where did you get that feeling...?*

Phoebe: *Well, probably because through the university training rather than the hospital training... a lot of reference was placed on talking to the patients and being the caring role... I mean we did get practical experience but you only had one patient... it wasn't a matter of trying to balance the load of seven patients you had that one patient and you had to try and find things to fill in all day with that one patient... so you*

were you know... talking to them and thinking more about their emotions... relatives and that sort of thing... so when I got to theatre I thought you know... I'm not on that exact same focus so therefore I'm not a proper nurse...

In contrast to Claire, Phoebe struggles with her history in a different way. We should perhaps be reminded here that Phoebe's education took place in a tertiary institution within the last five years and therefore, her perspective on what makes a 'good' nurse may be very different to that of Claire. Initially Phoebe says;

I've often felt after coming to theatre... perhaps you know... I'm not a good nurse... or I'm an uncaring person because... losing the opportunity to talk to patients didn't bother me so much... and I wasn't into the patient contact side [in theatre] I was into the scrubbing side and getting in there...

Phoebe's comment 'I'm not a good nurse... or I'm an uncaring person...' tells us that she has concerns about what kind of a nurse comes to the OR to practise. She wonders about herself and by removing herself from the role which is more visible to the patient on the ward, she finds herself in conflict with her image of a 'typical' nurse. Phoebe's history, her preparation to become a nurse may be viewed as quite different to Claire's, the expectation of Phoebe's education program was that she would interact extensively with the patient, exploring their experiences, rather than focusing on the completion of tasks throughout the day. In this section of the dialogue, she alludes to whether a 'good' nurse should go to the OR to practice when the good nurse is seen to be one who interacts with the patient.

I would suggest that the recent changes in education brought about by the move to the tertiary sector and a subsequent re-valuing of nursing practice have perhaps changed what is seen to be important (in regard to patient care) to the practising nurse. What I mean here is that students of nursing, through their education, are inculcated with the notion of involving the patient in both the determination of the nursing care provided and the delivery of that care, rather than performing tasks around (and upon) the patient. Phoebe's experiences of practice (informed in part by the values learned during her education) may therefore be seen to be quite different to those of Claire. Phoebe's removal from involving the patient in their care by locating her practice in the OR and the focus on the tasks required to be completed within OR nursing practice, appears to be causing her to struggle with the values which she learned throughout her education. I believe that example speaks loudly of our enculturation of a space for tertiary education within nursing practice and which now sees nurses within the tertiary sector and the hospital 're-value' roles associated with bedside or direct patient care (see Walker, 1993; Street, 1992).

Phoebe also tells us that in her nursing practice she *'wasn't into the patient contact side'*. Here we can recognise that the value of Phoebe's practice lay within the traditional technical/reductive approach to the provision of nursing care and which continues to pervade the view of what constitutes nursing care (Cheek & Rudge, 1994; Hiraki, 1991). These experiences of the world of nursing work contrast with Phoebe's experience of her preregistration education, in which she spoke of a greater value being placed upon interacting with the patient rather than 'doing' nursing practice.

Tertiary education of nurses the pursuit of nursing scholarship has resulted in the shift toward considering nursing practice as more than 'doing' nursing (Hazelton, 1993). Although, this movement has

effected a re-thinking of the values system inherent in nursing practice by nurse academics within the tertiary sector (Hazelton, 1993); the culture of nursing remains one of competing ideals and values for the nurse. These ideals and values I would suggest are perhaps a product of the location of nursing practice and the subtle (and not so subtle) differences in nursing culture(s). Each area of nursing practice, may therefore, have different ideals and values. Phoebe moved from an educational space which placed high value on the patient contact aspect of nursing practice, to a culture which places greater value on the more measurable, technical aspects of care. In an area such as the OR and the culture which in effect defines a good nurse as one who is competent across a wide range of surgical specialties, it is hardly surprising that Phoebe has moved to embody the notion of a good OR nurse which is defined by skills and expertise within the surgical domain. As she notes *'I was into the scrubbing side [in theatre] and getting in there'*. However, Phoebe's feelings in regard to OR nursing work are perhaps not as they first appear when later in the dialogue she admits:

I just feel like, naughty me... how could I possibly feel like I don't really mind losing the patient contact... because I should be caring about the patient and I should want to do all this sort of thing [talking to the patient]...

Her admission here serves to unsettle her previous affirmation that she was more interested in *'getting in there'* and highlights her struggle with how she experiences practice in the OR as compared to her experiences of practice in other locations and her history as a student. It is her student history which evokes the beginning critique of the way in which she now experiences practice. She appears to have some concern about the way in which she has accepted and embodied

nursing practice in the OR as compared to her understanding of nursing practice in other locations.

Phoebe reaffirms her position in the OR as one which is legitimate and acceptable due to the completion of a post basic course in OR nursing. This course has served to confirm her experiences in the practice world of OR nursing which possesses similar values, lets refer back to an extract of her earlier narrative:

Phoebe: *Yeah... because it is doing the theatre course that has changed my thinking towards the way I feel about my contact with patients... I just think well yes... this is where I am... I just do the best that I can here and that's fine... that's enough... I don't have to feel you know... that I'm inadequate or not a good nurse...*

Jill: *Yeah, so where did you get that feeling, where did you get that feeling of...*

Phoebe: *Well probably because through the university training rather than the hospital training a lot of reference was placed on talking to the patients and being the caring role. I mean we did get practical experience but you only had one patient it wasn't a matter of trying to balance the load of seven patients you had that one patient and you had to try and find things to fill in all day with that one patient. So you were you know, talking to them and thinking more about their emotions, relatives and that sort of thing... So when I got to theatre I thought you know, I'm not on that exact same focus so therefore I'm not a 'proper' nurse.*

Not being a '*proper nurse*', as Phoebe labels a nursing role in which it is necessary to converse with a conscious patient, was obviously of some concern to her in the beginning of her career as a registered nurse. As Phoebe experiences practice in the OR, she continues to struggle with the values conveyed regarding nursing practice within her undergraduate education. OR nursing practice with limited patient contact fails to mirror the educational values imparted to her, but as she states following the completion of her post basic operating room nursing course, '*I just do the best that I can here and that's fine... that's enough... I don't have to feel you know... that I'm inadequate or not a good nurse...*'.

Claire and Phoebe gain a sense of personal satisfaction from their work in the OR, both have chosen to locate their practice in the OR and both would have abandoned nursing if it were not for their enjoyment of their student placement in the OR. The stories told by these women serve to privilege the measurable technical aspects of nursing practice and confirm the possibility of a dominant technical approach to care (Cheek & Rudge, 1994; Hiraki, 1991).

Draping The Body — Creating The 'Object Body'

Our reluctance, as OR nurses, to spend time interacting with patients may be related to our views of the body within the OR. Claire and Rebecca both spoke of the way in which they view patients' bodies in theatre:

Claire: *You see when you're scrubbed you're not working on something that isn't a person... I mean you don't look at it as... as... you know carving a piece of watermelon... and what you were talking about [to*

Phoebe] last week... about your absolute fascination with it all... that's why I'm in theatre too... but it's... so that it's not an object that you are working on it is a person so you... treat it like a person... even though they're asleep.

Rebecca: *There's something very funny about it [how we deal with different situations] people say 'Oh how do you get on operating on children?'... and if we were to have Sophie [Phoebe's baby who is present at the session] in the operating theatre... and have her not covered up and do the things that we do to babies when they're covered up... I mean they look... we put them on the table before they're draped and so forth... it's a very personal thing... then when we cover them up and they are the part of the body that we are dealing with...*

Sarah raises the tension that exists between 'being there' for the patient in the OR and supporting the surgical team in 'getting the job done'. The expectations of the role and function of the OR nurse are such that the needs of the surgical team are addressed. It is in this way the needs of the patient/person are also perceived as being addressed by the nurses' attentions to the object body. Sarah's words introduce the notions of both the object body and the person raising the tension that is created by both the nature of the work of the OR nurse and the culture of the OR.

Sarah: *I remember the first time I went into the cardiac theatre I was standing there, I'd come from 2D and I was looking at this man that I had admitted and educated and done the whole lot... and I'm looking at him and I'm thinking 'Oh yeah'... then I'm looking over the*

[anaesthetic] screen into his chest... and it's this square and I'm concentrating on that... and I found it was very interesting... but being in a spot that I was looking at both... I found it really bizarre... I didn't know who I should be... I'd worked in theatre before and so I was thinking that this is the cardiac surgery and I'm very interested in what they [surgeons] are doing... but then I kept looking at this side and thinking 'Oh Mr. Jones, what are they doing?'... it was weird...

The work of nurses in the OR is centered around the repair and or treatment of the diseased/damaged body which lies upon the operating table. The process of surgery is objectified by the biomedical view of the person/patient, in that on entering hospital the patient's identity is inscribed with medicalised meanings which reframe their identity in accordance with ailments, diagnoses, treatment or investigations (van der Reit, 1997). Indeed, as people enter hospital for the treatment of specific pathologies, they are labelled as 'patient' and subject to the designated treatment by physicians and surgeons who deal in certain areas of the body. The objectified biomedical view of the body as a machine has formed a perspective in which the body is construed as an object of scientific investigation and treatment (Parker, 1997).

The preceding dialogue demonstrates how the OR nurses might view the body which lies on the operating table awaiting a surgical procedure. It appears that they share something of a struggle: the patient in the OR is defined by their surgical procedure and once the patient is inside the theatre, they are anaesthetised and placed unconscious on the operating table. Following the induction of anaesthesia, the patient continues to be prepared for the advent of surgery. The positioning of the person lying upon the operating table is directed toward maximum exposure of the area which is to be operated

upon to facilitate the surgeon as he performs the surgical procedure. As the procedure begins, the body is draped with linen to create a sterile field in which to operate. Draping takes place in a manner which limits the exposure of the body to the part(s) required for surgery. The draping of the body in effect hides the person who lies underneath and it provides a delineation between recognising the person or identifying only the body part.

Claire, Rebecca and Sarah spoke to their views of the patient during the operative procedures where the objectification of the body is perhaps at its most apparent. Claire refers to the person on the table and explains that when she is participating in an operation on an individual, to her, they are always a person. However, whilst she does this she also refers to the person as 'it' which may demonstrate a shift in her thinking between perhaps identifying the body as a lived body and then objectifying the body which aligns with the way in which the patient is viewed within the medical model. Lawler (1991:29) suggests that nurses are centrally concerned with both 'the object body (an objective and material thing) and the lived body (the body as it is experienced by living people)'. In the course of their work nurses may be concerned with integrating both object body and lived body (Lawler, 1991). I would suggest, however, that nurses working with the body in the OR are more constantly confronted by the object body as a result of the nature of work with unconscious persons and the exposure of individual parts of the body. Sarah's story illustrates the conflict she experienced through standing by the anaesthetic screen and moving, in her thoughts, between the patient she knew and her view of the operative procedure on the 'object body'.

Rebecca adds to Claire's narrative by introducing a further emotional factor to this issue, operating on a child. I think of children as innocents, as active in the world, a living child, before the drapes are

placed over the small form and the part of the child's body which must be operated upon is localised and exposed to the surgeon's. Rebecca speaks of the child as an individual with an identity which has an effect on those around her. Rebecca recalls *'it's a very personal thing'*, before the child is draped, then after the body part to be operated on is revealed Rebecca identifies that the child becomes, *'the part of the body that we are dealing with'*. To objectify the body, Lawler (1991) suggests, is a protective measure for the nurse. Indeed, I would suggest that the cutting open of another individual is a traumatic event and that the objectification of the body is influenced at least in part by this issue. In other words, the process of relegating the child's body to 'object' status enables the nurse to perform her role in the process of the surgery. The nurse during any surgical procedure requires her concentration and commitment to the process and outcome of the procedure. The expectation of the nurse within the OR, is that she is able to fulfil her role by supporting the surgical procedure on the 'object body'. This process of handing the body over for repair demonstrates a particular way of managing an abnormal life event which interrupts the normal activities of the patient and which Lawler (1991) argues is central to the maintenance of a hierarchical social order which circumscribes the care of the body.

Sarah notes her interest in the *'square'* on the surgery side of the anaesthetic screen which places a barrier between the patient and the wound in their body. This *'square'* further divides and demarcates the body between surgeon and anaesthetist by mapping out the territory of each specialist. However, when Sarah recalls looking back to the patient's face she expressed her concern over the procedure taking place inside the patient's body. Knowing the person in the manner she did, Sarah appeared to move from a position of being concerned with the object body to reconsidering the patient as a lived body (Lawler, 1991). Long, (in Lawler, 1991:56) claims that, 'our understanding of the body is

firmly interwoven with the nature of personhood and with the meaning of being human'. I would suggest that the foundations of Sarah's knowledge of the patient as object body were suddenly overturned by the recognition of the person who was subjected to the trauma of surgery. In this moment of recognition of personhood, Sarah may find herself identifying with the patient. The patient, this individual, is perhaps a brother, a father, a son to someone else. This view of the patient as a person with the nurse identifying with the patient I suggest, is a commonplace view of a central aspect of the nursing role.

Sarah's experience may serve, in part, to demonstrate how the OR nurse might view the unconscious patient within the theatre. However, it also allows us to theorise as to why nurses might hold these views. The placement of sterile drapes over an unconscious body and the subsequent limitation of the view of that body to the dysfunctional part, is discussed in the terms of the body being objectified: Claire labels the person as 'it' which is worked on; Rebecca states the body becomes 'the part' being operated on and Sarah is able to view the patient as the square on the other side of the anaesthetic screen. It appears that the draping procedures along with the surgical procedure and the focus on a particular part of the body also act to objectify the body.

Living the Drama — Medical Control in the OR

The patient hands their body to the surgeon and in effect symbolises the authority of the surgeon within the OR. In a study by Fisher and Peterson (1993:171), the authors speak of the surgeons' 'unquestioned authority' in the OR and found that nurses did not contest this authority. This 'unquestioned authority' of the surgeon may, at times,

cause moments of conflict, tension and crisis between nurses and surgeons and it is often lived out in dramas involving patients. As Sarah describes:

Sarah: We had an emergency which I scrubbed for... it was [a procedure for] a perforated duodenal ulcer which was bleeding heavily... the man was quite stressed... he was in his late forties... so he was fairly young... when he was brought up he was really listening... he was quite alert and he was in quite a bit of discomfort and Lisa [the anaesthetic registrar] was our anaesthetist and she was standing at his head and she panicked and started to yell basically... the surgeon on call... for general surgery was Robert [the surgical registrar] and we were waiting for Mr Jones [the consultant surgeon] to come in to do it [the surgery]... anyway, Robert wanted to go and scrub and... Lisa was saying, 'I'm not putting the patient to sleep until I see Mr Jones...' which is entirely understandable... and we all understood why [in case of the patient dying] and I was basically set up [with the instruments for the case] and ready and I was waiting... I was watching this man and I felt a bit bad because there wasn't enough staff on the weekend for someone to be with him and he really needed someone to be standing and holding his hand explaining stuff and... and... helping him really and there wasn't... there just wasn't the person for it except for Robert who wouldn't... and Robert started arguing with Lisa at this point saying... 'I can scrub up and start at least'... and this man [the patient] was really absorbing this conversation... I was watching... and he was really listening... the thing was Robert was down by the silver [store] cupboard and Lisa

was standing at the patients' head so that this was being shouted across [the theatre]... and everyone was just running for blood and everything... and Robert said 'I can start, I can open Mr Jones said he was on his way and he'll be here in five minutes or so...' and Lisa got irritated and so she started to yell and she said 'Look as far as I'm concerned I'm not starting until I see the whites of his eyes because as soon as this patient is open he could bleed to death, we don't know what's in there it could be a triple A [abdominal aortic aneurism]... it could be anything and you'll have no control and he'll be dead...' and I'm standing there thinking 'Oh my god...' the thing is she was standing there with her laryngoscope on the pillow next to him the other hand holding his head and he's lying there looking up at this anaesthetist going agro at the surgeon who he had met and knew was going to be operating... he hadn't seen Mr Jones so he would identify him, Robert [the surgical registrar] as the surgeon... saying as soon as he was opened he could die... bleed to death... and he [the patient] absorbed the lot, you could see it... and I couldn't do anything... I couldn't go over without contaminating myself or unsterilising myself... I couldn't say something because the patient was still awake... I couldn't say something [to Lisa] during the operation and afterwards she had gone anyway... when do you bring it up, who do you bring it up to? Probably [the theatre manager]... I don't know... but I felt that was... grossly... wrong... going to sleep hearing that... and there is... there was a possibility that he had... they didn't know if it was a 'triple A' or an ulcer or what... it was just incredible...

The situation recounted above filled Sarah with disbelief and despair. Her role in this scenario was defined by the fact she was to be the 'instrument nurse' and by definition she had a responsibility to have ready and available all instruments likely to be used by the surgeon in carrying out the surgical procedure. Sarah was wearing a sterile gown and gloves at the time and thus in her role was required to be 'ready for action' when the surgeon arrived. This meant that she felt that she was unable to venture in close proximity to this man (or to move in and stop the conversation) and hold his hand in some attempt to allay (what she perceived as) his mounting anxiety. As Sarah recalls, this situation occurred at the weekend when the OR is staffed at a minimum level for emergency procedures only. In Sarah's view, she felt there were no available (or spare) nursing staff to interact with the patient at this time and the medical staff appeared to be oblivious to the patient's attention to the conversation.

The gentleman lying on the operating table was in considerable pain due to the pathology of his condition. However, as Sarah mentioned, he was alert and aware of the 'discussion' which was taking place over him. Although he was alert this patient was treated as though he was invisible and/or oblivious to this exchange. Fisher and Peterson (1993) argue that the authority of the surgeon (which I am suggesting is in this scenario is being contested by the anaesthetic registrar),

... allows surgeons to control staff interactions with patients and to intimidate [and thereby] prevent other surgical personnel from intervening to protect patients from their actions and decisions... [and that] ...nurses submit to this form of authority out of feelings of powerlessness, fear of reprisal or belief that their input is unwanted (Fisher & Peterson, 1993:166).

The authors explain that nurses involved are unlikely to intervene in the situation on the patient's behalf, or report these incidents (Fisher & Peterson, 1993). This aspect of the OR culture creates and perpetuates

situations such as Sarah's story. In order to change the existing OR culture, I believe the conditions which surround situations such as these require challenging. Nursing staff (in particular) need to be able to appropriately confront the issues which produce such negligence. Sarah appears to be invisible along with the conscious patient. She finds herself both literally and metaphorically, handcuffed and gagged by the sterile attire which she wears and the exchange taking place between the medical staff. The ensuing argument between the two registrars effectively excludes all other nurses who are perhaps somewhat conveniently (if legitimately) busy gathering resources which (one hopes) will support the life of the patient during the procedure. As the instrument nurse, Sarah is required to be ready for the surgeon to walk in and commence the procedure. Even when the surgeon is absent his authority may vicariously manifest itself in ways which require the patient to be 'prepared' for surgery and the resources necessary to perform the procedure are gathered. Thus she must maintain her sterile attire in order to effect this. The authority of the medical staff and their subsequent control of the OR is perceived by the nurses to be a legitimate control; the nurses are socialised to accept this behaviour, just as the medical staff are socialised to expect to possess this authority (Fisher & Peterson, 1993). The unquestioned authority of surgeons and the power and control of the OR *in situations such as these* requires the OR nurse to either 'step in' on behalf of the patient and perhaps take control to avoid behaviour which may be considered negligent or to take action following the event so that the situation should not arise again. But nurses continue to remain silent.

In summary these stories reveal some aspects of the culture of the OR and the competing tensions in which the lives of these nurses are enmeshed. Whilst the literature speaks heavily of the 'perioperative' nursing role, it appears that apart from Rebecca's story in Chapter Four, there is little of a 'perioperative' nursing role in the nurses' narratives.

It appears that we reduce the individual to the 'part' we are operating upon at the time and we label the patient as the procedure no matter how hard we may try not to. The object body, as described by Lawler (1991) constitutes the medicalised view of the body and is imparted to nurses as the legitimate way in which to construct the body.

The stories told in this chapter convey something of the extent of medical authority within the OR. The data have served to suggest that the existing hierarchy within the theatre suite places the surgeon in command in a manner which excludes the input of others (non-medical staff) challenging the very notion of a team and, in fact, it serves to silence the nurse. Currently, nurses have little input into the care of the patient in the OR, the treatment of the patients is determined, in the majority by the medical staff.

In exploring the reality which constructs the practice of the OR nurse, it is necessary to raise the issues of nurses' complicity with their day to day experiences of their reality. If nurses experience the negative effect of situations and do nothing to change the course of events nor undertake any thought or action which will result in a change to their experiences in the future they are, in fact, complicit with and act to perpetuate the conditions which are unjust or unfair to them.

CHAPTER SIX: LOOKING BACK, LOOKING FORWARD — THOUGHTS AT THE POINT OF DEPARTURE

This thesis set out to explore how OR nurses describe their practice. The question attempted to tease out the understandings OR nurses have of their roles within the OR. This chapter raises major issues as an outcome of the study and briefly reflects on the research process.

Much of the literature written about nursing practice in the OR speaks to what 'might be' in terms of the role of the OR nurse. Authors such as Ladden and Keane (1995); Kneedler and Dodge (1991) and Pereira (1986) argue that developing OR nursing practice by undertaking the 'perioperative' nursing role would both advance the role of the OR nurse and secure the future of OR nursing practice. 'Perioperative' nurses then, not only move within the operating suite, but their practise includes observational and planning skills which encompass all aspects of the patient's surgical experiences. However, recent studies which have gone some way towards exploring the role of the OR nurse, indicate that whilst nurses demonstrate interest in and knowledge of the 'perioperative' role they are resistant to this role in practice (Conway, 1995 and Kalideen, 1994).

Although the 'perioperative' role seeks to expand and increase the profile of the role of the OR nurse, it also appears that 'perioperative' nursing practice may be an 'artefact' of nursing which seeks to emphasise nursing philosophy. It is claimed that the perioperative role provides nurses with a greater emphasis on patient centered care, an improved knowledge of the patient and thus, greater autonomy as they expand their practice across traditional boundaries in attempting to

provide total patient care. It is also believed that the status of OR nursing will be elevated through the perioperative nursing role.

In this study Rebecca was the only nurse who expressed a strong belief in 'perioperative' nursing. The position she held within private practice allowed her to extend the scope of her practice, and move in and out of the theatre, interacting with patients and their experiences. On her return to a large hospital she experienced difficulties as she attempted to introduce a similar role. Rebecca's experiences contrast with the experiences of Claire, Phoebe, Jill and Sarah who do not appear to adopt the practices of a perioperative role. Rebecca found herself constrained by the definition of OR nursing practice within the hospital and her inability to practise perioperative nursing.

It appears that the ideal 'perioperative' role written about by authors such as Ladden and Keane (1995), Kneedler and Dodge (1991) and Pereira (1986) is attractive to some OR nurses, as it was to Rebecca. However, it also appears to be somewhat unrealistic. The other nurses in the study appeared to place a higher value on their theatre roles *next to* the operating table *with* the surgeons, anaesthetists and an unconscious patient. Phoebe, Claire, Sarah, Susan and Jill all tell stories that indicate that we preferred to be members of a team inside the theatre and at the operating table. In Sarah's words:

... in those specialty areas everyone is equally as important... they're a team... you've got your job... your responsibilities... you're given a bit of credit ... whereas on the ward... the majority of the time I worked there [you weren't]...

Sarah's words convey to us that she pursued the 'team' aspect of practice in the OR and acknowledges that she was given some kudos as a nurse in the OR. Only Rebecca tells the story of coming to the OR

which includes the patient. With the exception of Rebecca, the rest of the nurses in the group told stories which positioned them in ways that met their expectations of nursing work in theatre by being able to get the work done, providing levels of job satisfaction and attaining a sense of elevated status in comparison to colleagues outside the OR.

The dream of the 'perioperative' role does not appear to have been well realised for the nurses in this study, furthermore with the exception of Rebecca the nurses did not place a high value on the role. OR nurses not only have to see a reason to expand their practice beyond the theatre doors which form the border of their practice worlds, they also must contest the medical control of nursing practice and the management policies and directions of the hospital. Perioperative nursing as a form of role expansion, is neither supported nor funded in current nursing budgets. Perioperative nursing is, therefore, somewhat rhetorical in the present day hospital economy. Perioperative nursing is suggestive of grandiloquent influences in contrast to being reality-based in practice.

Within the bounds of this study, I would argue that it is simply not enough for OR nurses to want to undertake a 'perioperative' role. It appears to be little more than the vision of academics who, it may be argued, are now some distance from the day-to-day reality of OR nursing practice. The bureaucratic machinery of hospitals in which both medical staff and the management have specific views on the scope of practice of the OR nurse and on any possibilities which might develop the practice of perioperative nursing. However, the attempt to develop a perioperative nursing role has been a logical progression in pursuit of professional recognition within nursing. In order for nurses in the OR to develop autonomy within their roles it has been considered necessary to contest the boundaries which contain them. In this way OR nurses have the opportunity to increase their knowledge

base of the patient by moving in and out of the OR with the patient. The perioperative role challenges the traditional boundaries of OR nursing practice and seeks to provide more comprehensive care for patients undergoing surgery. The proposal of a perioperative nursing role also raises the issue of technician versus nurse in the OR by suggesting a patient centered approach in contrast to one which is task centered. Writers and academics who have developed the perioperative role appear to have done so without the input of OR nurses. Reflecting on the stories told by the OR nurses in this study, only one has practised in this way in the past and she is unable to do so in her current practice context.

The nurses' stories reflect the powerful influence of biomedical knowledge and the control this knowledge exerts over nursing practice. The nurses share stories that tell of the ways in which they isolate themselves from communicating with patients, view the patient's body as 'object' and provide detailed accounts of the ways in which the powerful medical authority is present in the OR. We can be in no doubt that the biomedical presence within the OR influences the way in which nurses practice. The stories these nurses told represent ways of viewing the patient and the performance of surgical procedures which are powerfully reductionist and objective. It appears that OR nursing practice is directed toward supporting the completion of the surgical procedure. The patient does not appear to be central. However, I wonder if it is possible for the OR nurse to view the person and her practice in any other way, as the nurse's practice is directed toward assisting the surgeon with the removal of a diseased organ or body part, or the correction of the effect of trauma upon a person's body?

The operating room is a place of tension and conflict where nurses appear to take a silent and passive role. Sarah's story in Chapter Five tells of the messy lands of tensions and conflicts in the work place that

are revealed as the glamour, seduction and novelty of the OR fades. Sarah finds herself unable to act to protect the patient from the harm inflicted by the sequence of events, she is bound to her role of 'instrument nurse' and as the patient must undergo an emergency procedure, she feels she must be ready to begin the procedure at any time. The culture of the OR is such that the authority of the medical staff goes unchallenged (see Fisher & Peterson, 1993) and as such nurses are relegated to performing tasks within their role. Until nurses challenge the status quo the culture is unlikely to change (Fisher & Peterson, 1993). Studies such as this may provide nurses with greater understandings of the ways in which culture impacts upon their role (and their role impacts upon or supports the existing culture). Thus, OR nurses with such understandings may be able to consider possible ways to contest the status quo by becoming more proactive in decision making.

Some authors have attempted to advance the OR nursing role by seeking to increase autonomy within a 'perioperative' nurse role. They have advocated a form of role expansion which transgresses traditional boundaries and which is centred on the patient in contrast to the procedure. However, the 'perioperative' role appears to have been avoided by OR nurses and perhaps OR nurses are not interested in the role. It is possible that OR nurses recognise the 'perioperative' nursing role as currently not supported by hospital management in the current economic climate. If this is the case, then why should nurses challenge the boundaries for what they may perceive as unrealistic practice?

When one reflects on the research available to date which explores the role of the OR nurse and the OR culture, the paucity of work in this area leads me to suggest that more research is required which explores the culture of the OR and the impact this has upon the nursing role. In the light of my own study, I would argue that research with/in the OR

culture may provide information regarding the conditions which both shape nursing practice in the OR and govern the nurse's role. Research methods which utilise nurses' stories of their practice would assist other nurses to gain an understanding of the culture and seek to create change. Understanding how the culture shapes and is shaped by the nurse's role, may create possibilities by which nurses might then visualise or create for themselves a role which may be considered to be 'nursing' within the OR.

An ethnographic method enabled me to be a member of a research/focus group in which stories of OR practice were shared in an attempt to gain an understanding of the nurses' experiences in practice. The nurses who participated in this study all worked within one city hospital. The study may have been strengthened in the representation of OR nurses' practice experiences by collecting stories from nurses who worked in different hospitals, both public and private.

I set out to provide a descriptive account of how OR nurses might describe their practice. The clinicians who took part in this study shared their experiences of practice in a way that gave of themselves and allowed me as researcher the means to bring these words to expression. Clifford (1986) reminds us that ethnography is but a partial representation of culture and thus, so too are the experiences of that culture. Whilst this research may contribute to the literature which explores OR nursing practice, it does not provide us with 'concrete' answers to what the practice of the OR nurse might be. However, cultural studies may assist nurses to better understand their working conditions and the encompassing issues of power, gender and history in their day to day struggles.

The nurses' stories which informed this thesis provide descriptions of OR nursing practice. In addition to providing these descriptions the

thesis has attempted to raise questions about these practices and the conditions which shape them. The nurses participating in this study tell us stories of why they located their practice in the OR and their understandings of the role of the OR nurse.

OR nursing practice is I believe, in need of further exploration if we are to understand how we might go about challenging the status quo within OR practice. Further, I would argue that it is through understandings of culture in practice that possibilities are created for OR nurses to challenge not only their understandings and the development of their role, but also seek to challenge the conditions which act to constrain them.

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